THE U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

convenes the

ADVISORY BOARD ON

RADIATION AND WORKER HEALTH

VOLUME I

The transcript of the Meeting of the Advisory Board on Radiation and Worker Health before Debbie G. Williams, Certified Court Reporter and Notary Public; commencing at 8:30 a.m., Wednesday, February 5, 2003, at The DoubleTree Guest Suites, 181 Church Street, Charleston, South Carolina.

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MR. RUSH HENSHAW, NIOSH
DR. JAMES MELIUS
DR. SERGIO BUSTOS, SRSHES Chair

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I N D E X

VOLUME I
February 5, 2003

P R O C E E D I N G S

8:30 a.m.

DR. ZIEMER: Good morning, everyone. This is the eleventh meeting of the Advisory Board on Radiation and Worker Health. I'm Paul Ziemer, Chairman of the Advisory Board. The Board members are seated here at the table before me, and we're not going to introduce them individually. You can identify them by the placards in front of each individual.

I would like to indicate for the record that as best we know at the moment, Mike Gibson will be unable to be with us for this meeting. It is our understanding that Henry Anderson will be -- I'm sorry, I said Mike Gibson. It's Leon, isn't it, Leon Owens will be unable. I'm sorry. I hadn't heard that Mike wouldn't be, so maybe Mike will be joining us shortly. Leon Owens will be unable to be here for this meeting. It is my understanding that Henry Anderson will be joining the Board just a little later. There was a conflict that will cause him to arrive late.

I'd like to remind all of those in attendance today, Board members, as well as staff members from the various agencies, and members of

the public, to register your attendance with us in the registration book that's at the table near the entrance. If you are a member of the general public and wish to address the Board during the public comment period, we ask that you sign up to do so. There is a sign-up sheet for commenting during the public comment period, and that sign-up sheet is also on the table near the entrance.

There are a number of handouts on the other table in the rear of the room that includes copies of today's Agenda, copies of Minutes of some of the past meetings, and other documents that relate to the presentations that we will have today, so please avail yourself of those materials on the table.

We will proceed with the Agenda pretty much as its there. There will be some shifting on the times, as needed, depending on the length of presentations and the Board discussion periods, but in general we will proceed with the Agenda as indicated.

I would like to point out that originally a month ago when this meeting was confirmed there had been the intent that at this meeting the Board would discuss the provisions of the -- what we thought was the -- going to be the materials in the Code of

Federal Regulations dealing with the Special Exposure Cohorts. That material has not yet appeared in the *Federal Register* and thus, it cannot be included today as part of our discussion, and the Board members are already aware that that item has been removed from what was the original draft Agenda. The revised Agenda was, of course, on the web site and was promulgated accordingly.

I'm going to now turn the mike, or a mike over to Larry Elliott, our Executive Secretary. And Larry has some additional comments before we proceed in the Agenda.

MR. ELLIOTT: Thank you, Dr. Ziemer. I just wanted to welcome the Board to Charleston. I hope you find this city to be very interesting, and it is a very exciting city, so I hope you have some time to spend walking through the streets here and enjoy it.

As Dr. Ziemer said, the Notice of Proposed Rulemaking on additions to the Special Exposure Cohort has not gone completely all through the clearance process, and thus, we have not been able to put it into the *Federal Register* for public comment. We hope to see that very soon. And tomorrow we will have to take up in the Board's

housekeeping items your agendas for when we can meet to discuss that.

On your Agenda today we have a few -- a different -- a couple of different people to -- for you to get to know. I know you've met Martha DiMuzio in the past. Dave Sundin, who traditionally and regularly gives the Program Status Report to you all, is back home in Cincinnati minding the store. And Martha DiMuzio is here today, she'll be giving that Program Status Report to you. She's also critical to today's and tomorrow's discussion on the procurement and -- and task order development, so that's why I asked her to be here today.

And with that, I think I'll turn it back to -- to Dr. Ziemer.

DR. ZIEMER: Thank you, Larry.

You'll notice that the next item on our Agenda is the Review and Approval of Draft Minutes of Meeting 10. What I propose that we do is that we address only the -- what we might call the Minutes, it's the summary of the closed session, which was the executive session. The Minutes of those are not available to be made public, but the summary of the closed section -- or closed session can be made public, and is in the book and we will act on that.

The actual Minutes for the open portion of the meeting have been, or are being distributed, and they're rather lengthy. In fact, let me ask: Have they been distributed? Or they will be today sometime, if they're not already.

MR. ELLIOTT: I don't see Cori here right now, but I -- I know she's having the copies made.

DR. ZIEMER: In any event, those Minutes are thirty-some pages long, and I'm not going to ask you to glance on them and approve them forthwith. We will delay the action on those Minutes till tomorrow morning. I know you all were wanting to have something to do this evening, and that will -- that will occupy your time.

So without objection, let's simply move to the summary of the closed section -- closed session. It's in the tab that says: Draft Minutes/Meeting 10. That summary is very brief. It indicates who was in attendance, what the items discussed were, and when the meeting adjourned. And I have -- I have approved these in the sense that I have to certify that to the best of my knowledge they are accurate, but I would entertain a formal motion to approve these by the Board.

DR. ANDRADE: I would like to move that the

Minutes, as written, be approved.

MR. PRESLEY: Second.

WRITER/EDITOR: I'm sorry. Who seconded?

DR. ZIEMER: Second by, okay, Robert Presley, and everybody can fight over who the seconder is. The record will show that it was Robert Presley.

All in favor of approval of the summary of the summary of the closed session, say Aye.

BOARD MEMBERS: Aye.

DR. ZIEMER: Those opposed, Nay.

(No responses.)

And the Ayes have it. Thank you.

Let's move down immediately to the Program Status Report. And Larry has already indicated that Martha DiMuzio will make that presentation this morning.

Martha, we welcome you, and please take the podium.

MS. DiMUZIO: Good morning. I just want to welcome everyone again to the Board meeting. And basically what I'm going to be doing is presenting the program information that Dave Sundin has reported to you previously.

At the last meeting Dave provided

information which showed trends over the last five quarters, and basically what we've done is we've just added data for January.

What we have done is on January 20th, NIOSH and ORAU went to a new computer system. We switched over from an access data base system that was only used by NIOSH to an SQL system that's being used by both NIOSH and ORAU. Because of that, there have been delays in entering data into the system. We continue to receive information from DOE and DOL; however, it is possible that not all information has been contained. What we've done is we've done our best efforts to make sure that the information that we're providing you is as accurate as possible.

Again, DOL has referred over 10,000 cases to NIOSH for dose reconstruction. As was previously reported, we started receiving cases in October of 2001. If you look at the number for January, it's 314. We believe that number to be a little bit higher, but again, as of right now that was the information that we had, but we are still receiving, on average, 150 to 200 cases per week from the Department of Labor.

Again, we continue to send a letter to each claimant letting them know that we've received it

and how the dose reconstruction will be proceeding for their claim. Each case is logged into the system, we scan all their documents, and create and maintain a paper file for the system.

The majority of the claims involve employees who work at DOE sites, but about 16 involve employment at atomic weapons or AWE facility.

Each case file we receive from DOL lists the verified covered sites where the energy employee worked, and in some cases the energy employee worked at several covered sites. We use this information to direct our request for radiation exposure to the appropriate DOE office. We usually are able to issue the request to DOE within two weeks of receipt of the case.

If you'll note on requests that -- responses to -- responses from DOE for our requests, in the month of January there is an asterisk there. In December ORAU took over responsibility for receipt of the DOE responses. As I mentioned earlier, with switching over to the new SQL system not all of those responses have been entered into the system, so we didn't feel we could give you an accurate enough number for January; so hopefully at the next Board meeting we'll have an accurate number of the

responses that we received today.

At one of the Board meetings it was requested that we provide response information from the particular sites. The sites that are listed here are the seven largest sites for which we've requested information. And this listing represents 81 percent of the total requests that we have with the DOE. As you can see, we've broken it down by 60, 90, 120, and 150 days. As you're also aware -- excuse me -- so for those requests that are over 150 days we realize the importance of finding out from DOE what the status of that claim is; can you not find the data, have you just not started looking. So with ORAU -- excuse me, OCAS being given additional staff, we will start the process of contacting DOE on each of the individual claims that are over 150 days so that we can get the status of that DOE request.

Another thing is that these numbers should not be used as an indication of the quality of the data that we've received. In many instances, the DOE operating offices that have taken the longest to respond have in fact provided us the most complete information for the claimants.

A telephone call is -- a telephone interview

is offered to each claimant to permit them to add information which may be relevant to their case. The award of our support contract has substantially increased our capacity to conduct the interviews. And as you can see, in January alone, we have more than doubled the numbers of interviews that were conducted in the first quarter of 2003. As of today we have conducted interviews with 726 employees and their survivors, and more than 398 interview reports have been sent to the claimants for their review and comment.

We currently have 144 dose reconstructions underway. This means that we have received, assembled, and reviewed and evaluated the readily available information pertinent to a claim, and assigned the case to a NIOSH or ORAU health physicist.

Over the past month OCAS staff concentrated their efforts on reviewing the initial 62 dose reconstructions which were received from ORAU to ensure compliance with established procedures and The Rule. ORAU is currently updating those 62 dose reconstructions to incorporate NIOSH comments, and they continue to work on the additional 82 dose reconstructions. ORAU is also continuing to review

the individual cases to determine if there is sufficient data to complete a dose reconstruction. As this process moves forward, more cases will be forwarded for dose reconstruction.

This slide here shows that 16 claims have been sent; however, we've actually completed 18 right now -- two went out yesterday -- so for 18 claims we have completed the draft dose reconstruction report called for in The Rule, and have either forwarded or received a completed OCAS-1 form; so then of the 18 cases, 14 have been transmitted back to DOL, along with the complete administrative record for final adjudication.

Again, we encourage the claimants to contact us, and they do. The number of phone calls received in OCAS has received substantially each quarter as we receive more and more claims. And we are receiving on average over 100 calls per day.

Our web site is a rich source of information on the program, and is an increasing method of communication to others interested in the program. We received over 1100 claims-related e-mails and our goal is to respond to each one of them within 24 hours. And as you can see, the web site is being used more and more as a method of communication.

For our recent accomplishments, on January 24th letters were sent to 35 physicians appointing them to the DOE Physician Panels. And we're going to give those individuals approximately a week, and then we're going to contact them to make sure that they're still interested in participating, although we don't view that as an issue since it's been so recent that contact has been made with them.

And as you're aware, OCAS had been given an additional 22 positions and we've been working very hard to fill those. And as of -- as of today we have one new Health Physicist on board; we have two coming on board Monday; we have -- I can now update this slide -- as of yesterday afternoon we have three more Health Physicists coming on board March 10th, and which changes that two offers made there, that's now been updated. And we have five Public Health Advisors on board who will assist with claims processing, so we think we're -- we're moving along to hopefully move the claims faster through the system.

And I thank you for your attention. If you have any questions.

DR. ZIEMER: Thank you, Martha. Let me start the questioning, and then Jim will be next. I

just want to ask: On the web site, is anybody tracking the number of hits that the OCAS web site receives overall?

MS. DiMUZIO: No, we're not tracking that at all.

DR. ZIEMER: Thank you. Jim?

DR. MELIUS: I have a couple of questions, and I don't know if Larry, you may want to jump in. One is the issue of the DOE request for information. Can someone clarify on the situation? There was obviously two that stood out: Idaho and the Savannah River. And what is the situation with those two sites -- are these -- in terms of receiving dose information?

DR. NETON: I think I can help.

WRITER/EDITOR: Could we get his name?

DR. ZIEMER: Jim Neton of NIOSH.

DR. NETON: Jim Neton from NIOSH. I think -- let's see, Savannah River Site has -- has added staff, and in fact I believe we received 100 additional completed responses within the last week or so that aren't indicated in that slide. As Martha mentioned, we're switching over our system and we're -- there's a slight lag period updating that data base.

Idaho has moved a large number of boxes from their Federal Record Center in Seattle, and added staff. I believe they're working two shifts. I'm not sure of that, but I know they've added additional personnel; are going through the boxes and entering all the information in a data base, so there's going to be a slight lag period while they -- they do that, to pull the records out of those boxes, but once they do, we expect that to pick up very rapidly, so in short we're very pleased with the amount of attention that's been paid at those two sites to move things forward.

DR. MELIUS: But even -- I mean you have a number of outstanding requests at Savannah River, will they -- do you think the staffing -- so that was a staffing issue, and do you think the staffing is now adequate?

DR. NETON: Yes. I -- I can't say that it's adequate. We see a very large increase in the number coming over, like I've mentioned, 100 within the last week or so. And as Martha indicated, the claim responses that come from Savannah River tend to be fairly complete, so that when we do get a response, it -- it -- I'm not saying that a dose reconstruction could be done immediately because

there are other sites of the profile that need to be fleshed out, but in -- in relation to the monitoring results that we received, they are very, very good quality.

DR. MELIUS: And you probably explained this last time in the -- yeah, don't go away -- but are you -- are these completed, or initial responses? I mean what if you get sort of cursory information from a site?

DR. NETON: Yeah, that's -- that's right. These are initial responses. All that Martha presented was that we received an initial feedback from the -- from the DOE. Prior to ORAU coming on board though, we could not even -- we didn't have the time to look at all of them. We did a quality control spot check to make sure we were sort of getting what we needed. ORAU is now going through the process of looking at all of the responses and -- and issuing additional requests for information. We've particularly done a large number of those recently at the Hanford facility that have gone out. We're going to be tracking that and I think you should see this metric change in the next month or so to show an additional, you know, additional feedback on the -- on the responses that we send

subsequent to the initial one.

DR. MELIUS: So -- so will you set up a -- you'll have a tracking system that will cover both the second request and --

DR. NETON: Yeah, absolutely. In fact, all of that goes in the claimant's file. If we send an additional response, the letter goes in his -- in the claimant's file and is tracked within our system.

DR. MELIUS: Okay. So the -- the bigger picture on that: What's the status of the MOU with DOE, because that would appear to be sort of critical if people are not responsive or eventually not responsive.

DR. ZIEMER: Larry?

MR. ELLIOTT: Yeah, I'll respond to that question. The Department of Energy's Office of Worker Advocacy just put in place a new -- he's an acting director right now, but he will soon have the job is my understanding, Mr. Tom Rollo. I met with him and explained to him some of the issues that we have with some of the operating areas in the weapons complex providing us information. I told him that we really needed to get this MOU in place. He -- he immediately told me he would go wrestle it from the

DOE lawyers, and the next week we got a copy of it, so it had been languishing over there for, as you know, a number of months. We're in the, what I consider the final throes where it's with my general counsel now and -- and their general counsel trying to hammer out the last final details. I hope by the next meeting we'll have an MOU. There's considerable interest in DOE now, I believe, to see this MOU signed and put in place.

Let me also add that these numbers that you see that we give you in this program report are going to start to become more and more fluid. By that I mean we'll start -- you'll see the DOE/DOL referrals come to us, but we're also going to start subtracting those away that we finished out. We have -- I've established a policy in OCAS where the -- we're working on the first-come are going to be the first served, so each individual claim that has been sent to us from those that are in that category over 150 days of age, we're going to have a very detailed, specific status that when we have a phone call from the claimant we can speak very specifically about the status of that claim, and where it's at, and what it takes to move it to the next step.

Things are picking up speed. I assure you of that. We are seeing movement with -- with our ORAU contractor and in monitoring the DOE submittals on the initial requests. We are going to track, as Jim said, very closely the secondary requests that go out and monitor those. The Department of Energy understands that tracking system will either be a boon or a detriment to them in showing how well they are responding to our requests, so I think -- I think we're moving in the right direction and we're picking up steam as we go.

DR. MELIUS: Well, since you mentioned -- a follow-up to that. One is, I think it would be helpful to show similar data from the web site as well as on the -- at the Board meetings on the progress with the time line for the claims that are pending; how many are over a certain number of days. And I recognize until the contract was in place it was, you know, very difficult and it probably didn't make sense to do, but -- but I think that would be helpful information for everybody, and it would also then take into account the -- the component of that that's due to whatever the delay might be, whether it's the DOE getting information to you, a site where it's hard to find anybody that has

information, and so forth, so that -- you know, I think it would be very useful information in -- in terms of the accountability and progress of the program.

And I guess related to that question, it's sort of been stuck around 15 or 14 for a while. And I -- maybe I missed it at the last meeting, but I guess I'm sort of trying to get a sense of what the schedules when you're going to be starting sending more information over to the Department of Labor. I recognize that, you know, a lot of time has been spent getting the contractor in place and up to speed and so forth, but I think it's, you know, the number has been the same for a while, so.

MR. ELLIOTT: Sure. Sure. Well, as I hope you understand, we've been putting the machinery together to -- and the full implementation of this program. We're through that phase I think now. We're into the next phase, which I -- I would characterize as scaling up, you know, getting -- getting to the point where our through put needs to be in order to reduce the backlog that we have. It takes time to do these things. Why -- why we're only at 14 or 15, we -- we -- as we told you, we looked at the low-hanging fruit to use those claims

as a mechanism to test the machinery, and put the machinery in place, and make sure it was operational.

With the ORAU folks meeting our -- our stated expectations of 60 draft dose reconstructions by the end of December, they met that, they actually came in with 62, you know, on January 2nd or so. Those 62 are going to be forthcoming very shortly. They -- they are going to turn those around to us, in fact, you know, we -- it was a month ago we met and we have, I think, seven -- seven or eight in-house in our OCAS staff left. All of the new Health Physicists in OCAS will be tasked with doing dose reconstructions themselves as well, to make sure that they understand the process, the procedures, and The Rule that we have in place; show us they can do a few of these as well, as they start reviewing them, so we're going to -- we're going to move forward on a more rapid pace, I assure you.

DR. NETON: Yeah, I'd just like to add a couple of comments to that. I think what we -- what -- Larry's correct, and what you're seeing in that initial number of claims that came over were the ones that the OCAS staff actually started on. Our staff is three Health Physicists and we started, I

think, about 25, and Larry's correct, I think we just finished 18, so we have a few more to finish up. But we did select those based on not only low-hanging fruit, but different types of claims to establish the mechanism for doing them; the manner in which they'd be done. And as soon as the ORAU contractor took over we've been in the process of transferring that approach to them, and they've adopted it, and have maybe 60 or so that we feel fairly closely followed, you know, the -- the way that we started them, so we do expect these additional 60 to be coming over fairly -- fairly quickly.

DR. ZIEMER: Any additional questions, comments?

Okay. Thank you, Martha.

While we are on this general topic, I'd like to call on Jim Neton and Richard Toohey to also update us on the contractor status and activities. Jim, if you'll kick that off and we'll just consider this part of the Program Status Report.

DR. NETON: Thank you, Dr. Ziemer. I just have a -- I'm going to talk very briefly and then turn the bulk of this short presentation over to -- to Dick Toohey. But what -- what we'd like to

address briefly is the status of claimant correspondence; where we are with our -- our sending information to claimant and keeping them updated. I'm going to talk about what we have done within NIOSH to initiate that process, and then Dick Toohey is going to discuss after me what ORAU intends to do to communicate their activities to the claimant, and particular to address some of the issues that were raised at the Board meeting last month about transparency, conflict of interest, communication of the claimants as the -- as to how the policy is going to be implemented for particularly conflict of interest.

Very briefly, the white boxes you see on the diagram are the -- the letters that NIOSH already have in place and are communicating to claimant. There are five individual communications as you see. These are formal correspondence, not verbal or anything, these are just on formal letters that we send.

The first one is the acknowledgment letter that the claimant receives very shortly after we receive the -- the referral from the Department of Labor, and that tells the claimant that we received their claim and in fact that we have issued a

request to the Department of Energy for their exposure information. At that point, now we transfer the claim over to ORAU for the receipt of the DOE information.

The next step is the claimant will receive a phone interview letter informing them that we have an upcoming interview we'd like to conduct with them. The letter contains the -- it's not exactly the OMB approved script, but it's a summary of the lines of inquiry that we'll be going over, so that they can prepare in their responses. A summary of the phone interview is subsequently mailed to the claimant to allow them the opportunity to review that information and either correct or provide supplemental information at that time.

Once the dose reconstruction has been assigned and complete, currently the way it operates is a draft dose reconstruction is sent to the claimant -- and we've done this, as Martha indicated, 18 occasions now -- giving the claimant the draft dose reconstruction the opportunity to provide feedback, and if they concur that the dose reconstruction addressed all of their comments and -- and issues that were raised during the interview, the person, the claimant would sign an OCAS-1 form

and return that back to us.

Once we are in receipt of the OCAS-1 form, then we would issue the final dose reconstruction, forward copies to the Department of Labor and the claimant.

So that -- that's the current status. We're trying to -- ORAU is trying to integrate into this process, as you see, Dick is going to be addressing briefly the contents -- or the proposed contents of an introduction letter that tells them that ORAU is going to be taking over the dose reconstruction at that point. Currently our claimants, most of our claimants are not aware that ORAU exists as a contractor; they know NIOSH, so we -- we want to flesh that out and inform them a little better as to what the process is.

I think more importantly, the box on the lower left, the ORAU Dose Reconstruction initiation letter, is going to very informative to the claimant. That is the point at which ORAU will send a letter when they're ready to start the dose reconstruction and assign a person, that the claimant will receive a letter with the biographical sketch, and the ability to comment on the appropriateness of that person doing the dose

reconstruction. Dick's going to flesh that out in the next few slides.

So I think that's all I really have to say. I'll turn it over to Dick and he can discuss the other two boxes.

DR. TOOHEY: Okay. Thanks, Jim.

Let me talk first about the ORAU intro-letter. We like to think we're a very well known organization, but we may not always be correct about that, so we decided that an introductory letter goes out that briefly describes the roles and responsibilities of the ORAU team first making it clear that we are a support contractor for NIOSH, who retains responsibility for the process, and then a little information about ORAU and our partners, MJW Corporation and Dade Moeller & Associates. And we haven't actually decided yet, but I'm thinking the easiest way to do that just might be a tri-fold brochure we stuff in the envelope that's kind of similar to the tri-fold OCAS brochure. And really the information on that about the companies would be much the same that's in the disclosure statements and brief corporate histories that are in the Conflict of Interest Plan that's posted on the web page.

The important thing we want to get out to the claimant at this point is who should they call. We will be assigning a claim manager who is a Health Physicist, and a claim specialist, a support person not necessarily a Health Physicist. We have four of each, and we're assigning them to the four Department of Labor regions and they will be the principal point of contact with us for a claimant; so a claimant, any question, any issue, whatever, you know, this is the person to call and those people will be responsible for having the updated version of NOCDUS (ph) at their fingertips, know the status of that claim. They will also serve as sort of a technical manager just shepherding the claim through the interview and dose reconstruction process, and any glitches that come up, any problems we may have, it's their job to be aware of those, manage them, perhaps assist a dose reconstructor who needs to grab another piece of information for whatever to complete the dose reconstruction and so on. We'll include our 800-number, which is up, operational and staffed, and we're -- we're getting calls. It's only about 10 or 20 per day now, it's not at the NIOSH numbers, but starting to get used.

But also, what to expect, and just a little

reiteration of the process. So after this letter, the next thing the claimant should expect is the dose -- I'm sorry, the telephone interview letter. And reiterating, you always have the chance to supply more information. Anything you have you want to send in, by all means, feel free to do so. It will go into the administrative record. Then when the telephone interview is completed and the client's received and approved, or at least not contested, the report of the telephone interview then moves to dose reconstruction, and then they will receive the draft dose reconstruction with the OCAS-1 form and all that.

Okay. Then after the telephone interview is completed and they got back, then when the claim is ready to actually move into dose reconstruction, we've got the DOE exposure information we're going to get; the telephone interview is complete, as I said, and it's ready to go, the next letter to the claimant is a status report simply saying okay, your claim is actually moving into the actual, physical -- or -- well, yeah, it is a physical process of dose reconstruction. The key point here is the Health Physicist who is doing the dose reconstruction, and the claimant will be invited to

offer an objection of any sort to this person. There may well be a perceived or actual conflict of interest situation which, despite our best efforts, we're not aware of that the claimant may know about; personal contact, whatever. And we want to give the claimant that opportunity to object to this person; if they do not, then the -- say within a reasonable time frame, two weeks or so, and again by e-mail, by the 800-number, by a phone call directly to their claim manager, whatever method they want to use, we don't get a request for a different Health Physicist being assigned, then we will proceed with the actual dose reconstruction at that point. And then the paper trail goes back to NIOSH as we supply the draft dose reconstruction for NIOSH for review and approval. Then it gets sent -- the draft gets sent to the claimant with the OCAS-1 form.

Okay. Let me ask, any questions at this point on the proposed letters?

DR. ZIEMER: Rich, I'd like to ask a question about the -- let's say the -- I'll call it the issue of requesting a different reviewer. Have you developed some parameters on which you will decide whether the concern is a valid one? It seems to me that one could, in some cases, exhaust every

possible dose reconstructor for some facetious claims. How are you going to decide what will be a valid objection?

DR. TOOHEY: Well, we want to concentrate on conflict of interest issues. We certainly plan, and have hoped to eliminate, you know, conflicts from having worked at the same site, or -- or this, that and the other, things which we're all aware of, but there may be other things. I don't think the claimant would necessarily have a basis for judging the technical competence of this individual, although they'll have -- they'll have the bio-sketch, but we don't envision that as an issue. We think if the claimant has a -- a valid reason or concern, whatever that may be, we will try our best, but you have hit a key point, even though we've got a whole bunch of Health Physicists, it's conceivable we could run through the whole thing. A claimant could take the position that they don't want anybody who ever worked for DOE in any way, shape, or form, touching their dose reconstruction. And that's simply not -- not feasible to accommodate that, but, you know, we'll do our best to work with, and find an acceptable person. It's going to be easier in the early stages. As time goes on and we have all

our resources fully committed, we'll necessarily lose a little flexibility. I think it's also fair to apprise the claimant that if you do want another Health Physicist assigned, well, that's going to delay things another couple of weeks perhaps. Now, you know, if the claim has been in for a year-and-a-half maybe that's not a big deal, maybe it is. But we -- to answer your question though, we do want to concentrate on the conflict of interest issue.

DR. ZIEMER: Roy DeHart has a question.

MR. DeHART: Dick, if I understood correctly, you'll have four teams to cover all the claimants?

DR. TOOHEY: Correct. They're -- they're very similar to the Public Health Assistants NIOSH is using.

MR. DeHART: Has anyone modeled what the potential number of phone calls are going to be as you approach a thousand per team? I'm -- I'm serious, because in some of the research work we've done, we found people will call two and three times a day.

DR. TOOHEY: We simply anticipate it will be similar to what NIOSH is seeing now. We've got, I think, two full-time 800-number operators. We're

splitting the shifts so one works 8:00 to 4:00, the other noon to 8:00, so we -- we'll have that line covered 8:00 a.m. to 8:00 p.m. Eastern time. Simple questions, the phone operators may answer; something more detailed, they'll transfer it to the appropriate claim specialist.

MR. DeHART: That's my concern --

DR. ZIEMER: Rich -- excuse me. Rich, would you move your mike up a little bit? I think people in the back are having a little trouble hearing you.

DR. TOOHEY: I'm sorry. Is that better?

DR. ZIEMER: We'll see how it goes.

DR. TOOHEY: Okay. Thank you.

MR. DeHART: My concern is bombarding the four -- four teams with trying to simply address questions that are coming in, and without time to really be doing what they're supposed to be doing.

DR. TOOHEY: But that is what they're supposed to be doing. See, that -- that's the point. In discussions with NIOSH, we found some of the pressurization in the system they had was that handling these phone calls and dealing with the claimants was sort of an additional duty to what their folks were specifically assigned to do, and we said well, wait a minute, let's get people whose

specific job is to interact with the claimant, so they don't -- they're not doing the dose reconstructions; they're not doing the data retrieval; their job is to be there and work with that claimant.

MR. ELLIOTT: If I -- if I could make a comment. Your point is very well taken with us, Dr. Anderson -- DeHart, I'm sorry. I was thinking about Henry. Our Public Health Advisors are -- are, you know, we're setting them up to be the champion for the claimants, and to be there as the first point of contact, the NIOSH point of contact, so they're going to be introduced that way to each claimant. Each claimant is going to know who their Public Health Advisor is at NIOSH, that's their primary point of contact. The ORAU folks, complimentary to our Public Health Advisors, are these claims managers and claims specialists. So the way I think I see this working is our Public Health Advisors are going to, you know, work close in hand with their counterparts in the ORAU team. Once the claim -- the individual claim has transgressed to the point of moving into dose reconstruction, our Public Health Advisor is going to know who over at ORAU knows where that's at;

what's the status; they're going to know who has been assigned as the dose reconstructionist, and be able to talk collectively about the status of that -- of that claim. So we're trying to set it up so that a claimant has not only a NIOSH point of contact, but an ORAU point of contact. They can call -- choose whichever one they want to talk to about their claim at any given point in the process, and whoever they speak to will be able to pull up -- and you've seen our -- our -- what's called NOCDUS, our tracking system. Whoever they talk to, whether it's me, or the Public Health Advisor, or the ORAU team member, they're going to have the latest information on status to speak to about that claim for the claimant. So I hope this works; I think -- I think it will, but very concerned as you -- as you point out, the case load for some of these people, some of these teams. And -- and what we've seen to date is we get a lot of phone calls, but it's a minority, it's a vocal minority that we're dealing with. The majority of the claims that we have, we don't have any contact. People haven't started calling us yet, that's not to say that they won't. But right now that's what we see happening, and we also see different trends with different District

Offices within the Department of Labor. The Jacksonville Office and the Cleveland Office carry a -- a higher caseload than the -- than the Denver and the Seattle Office right now, so we're going to put our resources to bear on those two offices, and we'll shift as we need to as time and things change.

DR. ZIEMER: We have Robert next, I think, then Richard, and then Tony.

MR. PRESLEY: Robert Presley.

Dr. Toohey, the -- what they will need is their case number when they call the 1-800-number, that's number one?

DR. TOOHEY: Correct. That's the key access parameter, but again, we can search the data base, you know, name, Social Security number, or work site, whatever. We -- we -- and we're confident we -- we can find the record.

MR. ESPINOSA: There's been complaints about the summary, the letter summary not reflecting what the interview was, the total interview. And I think last meeting we discussed that there was not enough space on the computer program. Has that been addressed?

DR. TOOHEY: I'm not sure it's been completed, but it's certainly in the process. As

part of the roll-out of the new NOCDUS system on the SQL server there's also a new CATI, Computer Assisted Telephone Interview, data base system which has a lot more room and space on them, so --

MR. ELLIOTT: I would like to speak to that, too, though.

I'm sorry, Jim. Go ahead.

MR. NETON: I was just going to say that we have not fixed the program, but we are focusing on the review process now and making sure that all that information is there, so none, to our knowledge, have gone out that have been truncated because of the space issue. We take that out of the comment -- the response field and move it down into the comments field, so it's all there. And eventually it will be fixed in the program itself.

MR. ESPINOSA: And the letter is going to reflect everything that was said on the interview?

MR. NETON: Well, I mean I don't know that, you know, if it's a three-hour interview that we're going to have -- it's not a transcript, that's not the intent of it, but it will reflect everything that has to bear on the dose reconstruction itself.

MR. ELLIOTT: When you say the letter,

I think what you're referring to Rich, is

the draft interview report. And the reason why we give that back as a draft to the person who was interviewed is to give them an opportunity to make sure that they feel that everything was there that they wanted to see there, so they have the opportunity at that point to write in sentences or paragraphs that they want to see added that -- that they feel they spoke to in the interview, but didn't get captured. So it's, you know, it's a -- it's a redundant system; it's a -- it's a secondary attempt to -- to make sure all the information is captured that the claimant feels is important. We -- we've taken another look, another review at our interview process, and as Jim says, on some of the early interviews our process was for certain questions we had a certain character field limitation, and once you exceeded that, you were to drop down into the comment field, which is an unlimited space. And that was -- that was happening, but we were still getting, you know, some people were looking at that and seeing that some sentences seemed to be

truncated in -- in their original responses. We didn't lose the information, we just didn't fully and accurately portray it back in the draft report to the individual, and that gave them an opportunity to respond to us. So I think we've -- we've tended to that issue and we've made the corrections necessary.

DR. ZIEMER: Tony.

DR. ANDRADE: Okay. Moving beyond the activities that might take place after an issue with conflict of interest comes up and is perhaps resolved, please refresh my memory, Larry, or Richard, at what point does the claimant actually have the final opportunity for recourse to a -- a review of their dose reconstruction as -- as was put into the original legislation?

DR. TOOHEY: Well, there's two steps as I understand, although Larry Elliott may be better. They get the Draft Dose Reconstruction Report and the OCAS-1 form; signing the form does not mean I agree with the dose reconstruction, simply I have nothing more to add at this stage. And then there's also the appeal process with the Department of Labor, should the claim be denied.

DR. ANDRADE: So it --

MR. ELLIOTT: Does that answer your question?

DR. ANDRADE: Once the Department of Labor receives the -- is it the final?

MR. ELLIOTT: Once the Department of Labor receives the final dose reconstruction from us and the full administrative record, at that point they will render a decision, a recommended decision. At that point, on the recommended decision, the person has a -- has an opportunity to contest that decision, to appeal it.

DR. ANDRADE: Thank you.

DR. TOOHEY: Okay. If we move on --

DR. ZIEMER: Okay, Rich -- yeah, go ahead then. You have another slide.

DR. TOOHEY: Well, I think it's just one more. Okay. As I promised at the last meeting in Cincinnati, our project web page is up. The URL is www.oraucoc - Cincinnati Operational Center - .org. The biographical sketches of the Health Physicists performing dose reconstructions are posted on there. There were two of them up yesterday morning; I'm sure there are more now and we'll continue, even as we speak. We're concentrating on the people who

have already been involved in performing dose reconstructions, but eventually we'll get everybody out there.

And incidentally, I've distributed, you should have in your package, the latest measles chart. I know Dr. Roessler, in San Antonio, wanted to know how many Health Physicists we had working and who they were. Well, you now have that chart. There's 94 names on that chart with their qualifications, not all are involved in dose reconstructions, some are data retrievers and analyzers. The claims managers are also listed on there. I'm listed on there, also. I don't know if I will ever actually get to do a dose reconstruction myself, but I -- I still plan to someday. The -- there are five more people I'm aware of we'll be bringing in. And just remember, that roster is a fluid document, people will be coming on and -- and dropping off of our roster. The -- and the majority of folks on there, certainly listed under MJW Corporation, are part-time dose reconstructors, and will be given a file to perform the dose reconstruction and sending it back in. For ORAU, several consultants are listed, Peter Groer, University of Tennessee; Dick Griffith, Nancy

Daugherty, are also part-time consultants on this project, but most of the other folks listed on there are full-time assigned. Only Dade Moeller & Associates are full-timers, for example. So I hope that satisfied that one request.

The disclosure forms are also being scanned in and posted on the web page. We have also, we will have more information about the project, and again list our 800-number and the links to other sites. And again, that's also a work-in-progress, but it is up, or at least it was yesterday, I haven't tried today.

Okay. I think that's all I have.

DR. ZIEMER: Okay. We have -- stay there, Rich, for a few minutes.

Jim, you have a question?

DR. MELIUS: Actually, my question goes back to the earlier presentation. I've had time to scribble some numbers, and I just had some questions about what was presented. Regarding the DOE response and whose -- the numbers are not important necessarily to answering the question, but the reason I'm asking it, if I do this correctly, this table that you showed with the list of the sites, there's a selected number of sites, I assume it's

the ones with the most requests out. You cover roughly 6800 -- you actually have a total of 8400 requests out to DOE as of the end of December for information, so there's roughly 1600 that are missing from this table. If the numbers are right, you've received requests -- response back, about 4800 total, of which 4500 are left in this table, again, roughly, which is a low percentage, if those numbers are right and they may not be, it's roughly 300 out of the 1600 requests that responded to them, so I guess my question is: What other sites are there problems with? It would seem to me that, you know, are these two the ones that stand out in terms of this, and I mean are there delays at other sites? I don't --

DR. ZIEMER: This, presumably is over 80 percent of the total requests to the DOE, is that correct?

MR. ELLIOTT: That's correct.

DR. MELIUS: Yeah, that --

DR. ZIEMER: That's the DOE, but not to the other contractors, right?

MR. ELLIOTT: That's correct.

DR. ZIEMER: These are the DOE sites on here?

MR. ELLIOTT: What's not on here is like a Nevada test site. They have a very good response with us, but very -- not a -- not a large number of claims. I don't know if Jim or Martha could help me out here in the other sites, but these are the -- are the main sites that we have the largest numbers of claims represented for.

DR. MELIUS: And I guess my question is not even knowing which sites are involved or who's responding or whatever, it's that you do have a tracking system in place to deal with all the sites, and then it would seem to me if we identify sites that are lagging, even though they're not a large number of claims out there, and look into them and see what -- what's the problem, or --

MR. ELLIOTT: Right. And that's exactly what we've done with -- with INEEL and Savannah River Site. They have been traditionally our poorest performers as far as responding, but when they respond the quality of the information they give us is very, very good, compared to some other sites where they are quick to respond, but the quality is not what we're seeking.

DR. MELIUS: And then I think over time one could then sort of look at, well, the second

request, so what's the total time it takes to get an adequate amount of information from the site. I think as long as you have a system in place to do that, I also think that ought to be, you know, sort of a transparent system once it's up and running so people know and the claimants can tell --

MR. ELLIOTT: Sure.

DR. MELIUS: -- you know, what's the average amount of time, what's, you know, is their claim unusual for some reason.

MR. ELLIOTT: As we tracked and monitored these statistics and we saw INEEL and Savannah River continually, you know, late in -- in responding to us, that's when we went back to DOE and we said what gives here, why -- why is this going on. And through -- there's a -- I forget the name of this group, but there's a records group that meets on a weekly basis and they talk about these things, and -- and it came to light that there was a misunderstanding at Hanford and that was -- or at INEEL, and that was causing some of the problems. And so once we got them on track with what we were really wanting, they started providing it. And then Savannah River, we found out that they were just so short staffed, and we applied some pressure, and

they got some more staff. So we're using these statistics that way, to go back and pressure where we can.

DR. MELIUS: Just to follow up. I mean I think as this program gets more complex, and particularly your working now through a contractor, having this sort of a system in place and making that information available, it's going to become even more important. Is now a time -- I mean you know internally what's going on, I'm sure, Jim, and deal with it, but as it gets sort of spread out and the numbers get bigger, it's going to get more.

DR. ZIEMER: Okay. Gen Roessler.

DR. ROESSLER: Thank you for this list of people involved in the team, which we had asked for some time ago. It does give us a chance to, at least on a preliminary way, evaluate the quality of this team, and I've looked through the list and I'm really impressed.

MS. MUNN: It's impressive.

MS. ROESSLER: It's very impressive. I think in particular, this is not the only measure, but there are a high percentage of people under the CHP column, which is Certified Health Physicists, which speaks to the quality of the team, so I -- I

appreciate this.

DR. ZIEMER: Thank you.

Other comments, questions? Yeah, Larry.

MR. ELLIOTT: Before you step down, Dick, in the -- am I right in the next couple of weeks we're going to see some assignments for dose reconstruction to occur? We've got a number of CATI's done, a number of interviews completed, and we're going to see ORAU start making assignments of dose reconstruction, and that's why it's important for -- for your integration letter -- introduction letter to get integrated into this -- this process, so.

DR. TOOHEY: Correct. And as you know, the drafts of those letters have been going back and forth between us and OCAS, and I think we're very close to agreement on the final wording and those will be routinely going out.

MR. ELLIOTT: So the Board and the public understands, what's happened up to this point is for the 62 that ORAU took on, and you know, to make sure that -- that their folks understood the process and we were using the right methods, we did not approach the individual claimants with who is doing the dose reconstruction, so we're going to have a two-part

process here; for those 62, they're going to get a letter from ORAU or from us, I'm not sure which yet, that says here's your draft dose reconstruction report and here's who worked it up for you, your dose reconstructionist was, and here is there bio-sketch; if you have an issue with this, make it known now. And then from, you know, in the next couple of weeks as we start assigning dose reconstructionists to claims, before the work starts a letter will go out from ORAU introducing the dose reconstructionist and seeking any objection.

DR. TOOHEY: Yes. If you'll recall, those 62 were -- I don't even call them draft dose reconstructions, but rather, test dose reconstructions and they were simply to be delivered to NIOSH for review. Are we doing it right? And generally, the answer was yes, and we've reviewed the comments and responded to that, tweaked our procedures a bit as needed, so we're -- we're ready to start cranking on these things.

DR. ZIEMER: Okay. Roy, and then Jim.

MR. DeHART: A simple question. Once the models are complete, could those be e-mailed to us so that we can just have a look at them and know what to expect should we get any questions?

DR. TOOHEY: The model letters?

MR. DeHART: The model letters, yes.

DR. TOOHEY: Sure. Yeah.

DR. ZIEMER: The same comment?

DR. MELIUS: That was the same comment.

DR. TOOHEY: We'll put them on the web site whenever it will be. Fine.

DR. ZIEMER: So someone will make sure that -- staff will be make sure that occurs. Thank you.

Other comments? Other questions for Dr. Toohey?

DR. ZIEMER: Yes. Mark?

MR. GRIFFON: I'm not sure if this is appropriate for now, but I was curious just the status of getting your program developed, you know, the procedures that are under development; check bases that are under development; some that are completed, whatever; and if there was a listing of those things that were either in draft or finalized.

DR. TOOHEY: There's a listing of documents, including procedures, we supply that with our monthly report to NIOSH. I can certainly get you an update on that. And -- and incidentally, I should comment on the -- the test dose reconstructions. They will not be considered final, and then sent to

Labor until the procedures have been finalized and approved, so that, of course, I'll get a final review stage to make sure that we didn't miss something in accommodating those, but as they move into the final dose reconstruction step, they will be on that.

The internal dose reconstruction procedure is currently with our document manager for review and approval. That's pretty close to finished. She's working with Grady Calhoun, who's our NIOSH contact for document approval on that one. The external dose reconstruction procedure, we've got a draft in for review now. It may another week or two before that's finalized.

DR. ZIEMER: So, Rich, you will have a some sort of a compilation of approval procedures and --

DR. TOOHEY: Yeah. Well, and we --

DR. ZIEMER: -- perhaps that can be made available --

DR. TOOHEY: -- we can certainly put the --

DR. ZIEMER: -- as well.

DR. TOOHEY: We can put the list on the web page, and I don't see any reason not to put the procedures out there if you would like that, also.

DR. ZIEMER: I think there is a sentiment

for having those made available.

DR. TOOHEY: Okay.

DR. ZIEMER: Thank you.

DR. TOOHEY: We've got plenty of server room.

DR. ZIEMER: Other comments? Mike Gibson.

MR. GIBSON: Just one concern for the record, it's not really relevant to, you know, I know that you're working on the conflict of interest and everything else, but just running through the list, I am somewhat concerned with this one -- of this shallow pool of Health Physicists and internal dosimetrists, there's going to be enough left at the sites to do the current work to make it accurate to -- to send forward to this dose reconstruction process.

DR. TOOHEY: Yeah.

MR. GIBSON: I notice here there's six to eight from Mound that left the site, and went to work for ORAU, or one of their subs.

DR. TOOHEY: And of course, that's because Mound is, as you know, closing down. We've picked up refugees from Fernald. We're competing with NIOSH for the same people, they're adding to their staff, as so are we. And -- but actually, we think

the solution to that is really what we've developed, and it gives us a lot of flexibility, is to have the majority of dose reconstructions done by part-timers who are acting as independent consultants to ORAU or one of our subcontractors. And after, you know, we've got a huge bolus to work through on the backlog, but then as things slow down after that, you know, those people would be not as busy as previously; but, no, I agree with you, it is an issue. There's -- there's a limited pool of competent dosimetrists out there.

DR. ZIEMER: Tony has a comment.

DR. ANDRADE: I'd like to respond to Mike's comment by informing the Board and visitors here that normally the folks that do respond, at least the folks that I'm familiar with that do respond to requests for raw data on doses, on situations, on facility information, and so on and so forth, are not necessarily Health Physicists at all. Those folks are usually document specialists who have been trained in handling nuclear facility documents, who have also been trained on the job for the most part, on some aspects of health physics, such that they provide the appropriate types of dose information; for example, on a yearly basis, rather than a

committed effective dose equivalent, which is what they're interested in using for dose reconstruction, so they're like ARMA (ph) members, and that sort of thing.

DR. ZIEMER: So they are not dose reconstructionists, is what you're saying?

DR. ANDRADE: Exactly.

DR. ZIEMER: And may not be competing with this pool. Thank you for that comment. DR. TOOHEY: Okay. Well, I --

DR. ZIEMER: Go ahead.

DR. TOOHEY: I was just going to say I understood Mike's question to refer to we're stealing health physicists from the operational dosimetry departments at the sites to work on this project, and well, if people want to vote with their feet, then you know, I have no objection.

MR. ELLIOTT: One more comment that we've received at OCAS that I would like to share with the Board and the public here, and that's a comment that's come to us about the need to be aware of national security information as it -- as it comes forward in -- in an interview process. We're very concerned and very much aware of our obligation to protect that kind of information. And in our

interview process we feel that both the person being interviewed, who has held a clearance at a DOE site, and understands this, and ourselves have an obligation to raise that warning flag at the earliest point in this process and say, I can't talk over the phone about these kind of matters; we need to do this in another setting. We accommodate those situations as soon as they are identified. In fact, we have done, I believe now, five secured interviews. The interview is -- once the interviewee identifies that they've got a problem of this sort, we stop the interview and we reschedule it in a secure location, and hold the interview with a derivative classifier at the ready to make sure that the notes from the interview do not breach National Security, but we get the information that we need to process the claim. So if there are any comments or questions that come to Board members about our interview process and National Security information, please, you know, feel free to respond that way or -- or bring them to me and we'll make sure that we effectively handle and -- and deal with those kinds of inquiries.

DR. ZIEMER: Okay. Mark has a question.

MR. GRIFFON: Actually, probably to Larry,

just to follow-up on that. I guess I would just question or wonder the approach you're going to take because in my own experience at some of these sites is that especially the older employees tend to err on the side of conservatism when it comes to classified information, and they'll just assume that everything that was classified in 1945, 1950, remains classified today, and there may be some real relevant information -- and you know this as well as I do, that you could sort of squelch the interview unintentionally probably, but I'm wondering -- and that tends to be site-specific too, as I've learned through my work, so I wonder how -- I just -- I throw out that caution that I think we want to encourage the interviewee to give as much about their work history as they can without crossing that line into National Security issues certainly, so.

MR. ELLIOTT: Your point is well taken, and we -- we certainly recognize that some of the older, former workers, you know, who have come from that culture may not be aware that some of the more, you know, more recent declassification of information has occurred. But we -- we still don't want to see them put in a situation where they feel that -- that they're breaching National Security, so our approach

here is to stop the interview and reschedule it in a secure location where they can talk to us about whatever they feel that is appropriate and necessary for us to hear to process their claim. I've seen it work. I think it works for these five that we've done. I personally have been involved in -- in trying to secure classified information from certain sites, and it can be done, but we want to make sure that we -- we do it right.

DR. ZIEMER: Jim Neton has an additional comment.

DR. NETON: Yeah, I'd just like to add a little to that. We do have three more classified interviews upcoming in the last couple of weeks that ORAU ran across. And the approach we've taken with this is if a person indicates at all that they have a concern because of classification issues, we ask them, because they all have a chance to review the questions in advance, are your concerns at all related to the lines of inquiry, the questions that we are asking, and if that -- if they say yes, then we -- we do not even proceed to the interview at all because we feel that it may even divulge classified information by knowing which questions are classified kind of thing, so we'll stop it and then

offer them and say we will -- we will set you up with someone who is familiar with classification and proceed at that time, so then they will have the opportunity to proceed. We don't do partial interviews, I guess that's what I'm saying.

DR. TOOHEY: And let me also add ORAU has about a dozen employees with active Q Clearances available to supplement NIOSH staff as needed.

MR. GRIFFON: I know that one way we dealt with this and I did -- I did do some classified interviews at Oak Ridge on my medical surveillance work that we did down there; but also, one way that Oak Ridge encouraged us to do this, Gabe Marcianta, I believe the security contact down there, actually did a briefing and had -- I'm not proposing that, but maybe site-specific write-ups on what has been declassified, so it almost -- his briefing -- actually I was quite nervous going in having him brief these people, I thought oh, boy, this is really going to shut everybody up, but actually it worked -- it actually worked the opposite. He said to the older employees there -- the older retirees there that the following things here have been declassified, and feel free to divulge information regarding this if -- if you feel so fit, and, you

know, otherwise, if you still feel the need to go to a classified interview we can make arrangements to do that. But we were -- we were trying to avoid having a lot of classified interviews, so maybe that's a possible approach to have sort of site-specific write-ups from -- that could be sent with questionnaires. I don't know, it's just a possibility.

DR. NETON: We had discussed that with the Office of Worker Advocacy and I -- I think it's still under discussion, what you're suggesting. I think it's a good idea.

DR. ZIEMER: Thank you. Any others? Thank you, Richard, for that --

DR. TOOHEY: Thank you.

DR. ZIEMER: -- update on your activities.

You may recall that at a previous meeting, I think it was two meetings ago actually, we talked about some possible updates on the IREP program relating to latency periods for leukemia and thyroid and Russ Henshaw is going to give us an update on that issue now. And I think in your packet there -- yes, there is a tab in your packet that has Russ's overheads.

Russ.

MR. HENSHAW: Thank you, Dr. Ziemer. Okay. Can everyone hear me okay?

Good morning. I do want to update the Board today on where we are with this whole minimum latency issue regarding thyroid cancer and leukemia. And I'll also discuss some other IREP issues.

And Dr. Ziemer, I certainly don't mind taking questions from the Board at any time.

And I'll start with the latency issue, and again, we're using the word latency here really as a shorthand term for the time between exposure and diagnosis. So I'll recap briefly what we presented in October, and I'll give you an update on how we intend to deal with the issue now. Recall that back in October, which seems hard to believe that was four months ago already, but back in October we presented sort of a status report on -- on the issue of latency for leukemia and thyroid cancer. We were concerned that NIOSH/IREP awarded no risk, no probability of causation for radiation exposures that occurred within two years of diagnosis for leukemia, and within three years of diagnosis for thyroid cancer. We asked SENES Oak Ridge, Incorporated, our contractor, to come up with a -- an adjustment for that, a new model that did factor

in some non-zero risk for those short latency periods; they did so, and we presented that first model to you in October.

If you recall, our feeling at NIOSH was that the science just simply did not support such a severe and absolute adjustment function for these two cancer models, and again, that was different from all of the other cancer models at IREP; all other cancers IREP awarded some probability of causation at all times since exposure, these two were the exceptions.

While we evaluated that model that SENES developed, or those two models that SENES developed back in the fall, one of the unanticipated -- well, the unanticipated effect of the new models was that they actually reduced probability of causation at some time since exposure, although they did factor in probability of the short latency periods. We were uncomfortable with that; we didn't feel that the science supported an adjustment that would in effect reduce probability of causation at any time since exposure. And that's pretty much where we were at that time at the October Board meeting.

We asked SENES to pretty much go back to the drawing board and look at that model again and come

up with a new adjustment, and we specified two conditions. And we asked them specifically to develop a model where -- that would not have the effect of reducing probability of causation at any time since exposure when compared to the current model, and also still factor in some non-zero risk as appropriate at all times since exposure, even if you're a zero. They did that, and developed those models and presented them to both NCI and to NIOSH, actually just in December, just less than two months ago.

I do have a table here of probability of causation results, and I'm going to just briefly explain the table if I can -- if I can do this without screwing things up -- there we go. This is for leukemia. This involves a set of hypothetical claimant inputs: A man born in 1930, diagnosed with leukemia in 1980, using the cancer model leukemia, excluding Chronic Lymphocytic Leukemia, just for simplicity, we used one acute exposure at 50 CentiSieverts; we used a constant dose, in other words, no uncertainty in the dose input, and photons greater than 250 keV. Then we used the default sample size in IREP of 2000, and the default random number seed of 99.

Now, just to explain the table, first of all, this is the -- this is a column of results for the current IREP, the one that's on our web site. These are the results for the model that was developed back in the fall, that first alternative model that we showed in October; this is the new model that was developed in December. And going over to the left, the left column is the age of exposure; the year of exposure; and then the times since exposure in years; so this person, this hypothetical claimant born in 1930, exposed in 1980, would be 50 years old, same year of exposure as the diagnosis, so that's zero -- zero year since exposure. The current model, of course, would give that zero probability of causation; the model in October would have awarded just for that one exposure, two percent, a probability of causation equal to two percent; the new model, 3.6 percent, and so on.

You can see that, from this hypothetical set of inputs all -- the two conditions are -- are satisfied by the new model. Now, to fit it onto the slide, I truncated this, and you see his time since exposure from zero to five years, and I skipped to ten, and then intervals of five, but these

conditions are met also in years six through nine. In fact, for leukemia you can see that by year five it's pretty much identical, and stays very close on throughout the series.

By the way, we're not too far off with our hypothetical set of attributes. I looked at our claims data base, and this, as of January 23rd, just as an aside, for all leukemia claims excluding CLL the mean age of our claimants is 19 -- or excuse me, the mean year of birth is 1927; the average first exposure, 1958; the average last exposure, 1977; the average year of diagnosis, 1987. That's based on 334 claims as of January 23rd, 2002.

The new model, the new alternative model, this far-right column uses a midpoint or the S-shaped function, if you recall that -- that lingo from October, the S- -- the S-shaped function is the actual adjustment that reduces probability of causation for short latency. The midpoint of the new model is 2.25 years. That's a change from three years for the -- that first model that we showed in October. And to account for the uncertainty, it actually -- it adjusted the midpoint from 2 to 2.5 years; the midpoint is 2.25, it adjusts from 2 to 2.5.

Any questions on the table before I move on?

DR. ZIEMER: What -- remind us again, what does the curve look like at the low end? In the previous one they had proposed a linear function between zero and two years, was it, or not?

MR. HENSHAW: Well, recall that --

DR. ZIEMER: Well, originally, you had a stepping function, but then the -- the one you talked about in October between zero and two years, was it linear?

MR. HENSHAW: Well, remember that IREP only uses whole years --

DR. ZIEMER: Right.

MR. HENSHAW: -- for adjustments.

DR. ZIEMER: Okay.

MR. HENSHAW: So the --

DR. ZIEMER: So they were just point values?

MR. HENSHAW: Yeah, the graph I had in October I think may have been a little confusing because I had -- I had it drawn that way.

DR. ZIEMER: Yeah, the dots. Yeah.

MR. HENSHAW: Yeah.

Okay. To move on to the new adjustment for thyroid cancer, it's the same set of hypothetical inputs. With -- with thyroid cancer you can see

that the probability of causation for the three models converge on this table of ten years. Again, it's truncated, so I don't have years six through nine on here, but it actually converges at about eight years. From that point on, the thyroid cancer that results are virtually identical. And you can see that the conditions we specified are satisfied here as well. For the model on the web, no probability of causation years one through three, that was the October model; the new model addresses those other concerns and still factors in -- still factors in the appropriate probability at each interval. One thing I noticed, this is just by chance with this hypothetical set of claimants, but the new model actually would make the difference between compensation and no compensation at a time since exposure of five years, as you can see there, 47.3 versus 56.3. Of course, you know, most of the claims, there are a series of exposures and this -- this single exposure would be just one of the dose inputs into IREP. By the way, I looked at also our average claimant for thyroid cancer, and again we're not too far off on this hypothetical set of inputs. The attributes of our average -- the average DOE worker with a thyroid claim in our data base was

born in 1934; was first exposed to radiation in 1964; the last exposure, 1983; and the average year of diagnosis was 1989. The thyroid S-shaped curve, the -- the new model, again the model on the right, has a midpoint of 5 years with a variance around the midpoint ranging from, I believe it's 4.5 to 5.5. I'll double check that. The old model had the same -- not the old model, but the first alternative model presented in October had a midpoint of 5, but varied from 3 to 7 at the midpoint, so this tightens that up to address the problem of not reducing probability of causation at any time since exposure. Any questions on -- this is pretty dry stuff, but any questions on any of this before I move on to other IREP issues?

DR. ZIEMER: Russ, one other question and maybe comment. This -- this is done specifically for claim issues. How -- is NCI planning to utilize this model in any way?

MR. HENSHAW: Well, that's -- that's an interesting question. Actually, back in October our understanding was that NCI's intention was to adopt the -- the model shown in this (indicating) column. Since that time we've had some discussions with NCI, and also with SENES. As you may know, SENES is also

the contractor for NCI, as well as NIOSH, so we've king of got a three-way working relationship on this. And as of about two weeks ago, or my understanding is that NCI has shifted on that, and now intends to adopt -- or is leaning towards adopting this latest model that was presented in December. I think they have some internal discussions and, you know, issues to resolve there, but that's -- that's what our understanding is as of a week or two ago. So we'll be in harmony there.

DR. ZIEMER: Well, presumably the -- the science itself doesn't support one versus the other intrinsically. Is that a fair statement? So that the real reason for doing this would be to -- for us, would be to provide some degree of consistency with how we handle claimants in terms of the non-zero values of the other coefficients of the other cancers.

MR. HENSHAW: Yes, I believe that is a fair statement.

DR. ZIEMER: Scientifically, you can make the case for either I guess. Is that true?

MR. HENSHAW: Yes, that's correct. Latency --

DR. ZIEMER: Or you could equally not make

the case for either, which -- however you want to look at it.

MR. HENSHAW: The latency is perhaps the hardest aspect of the modeling to actually -- actually do, and the science is rather ambiguous on it, especially with respect to leukemia; it'd be less so for thyroid. But we felt that this -- this was one of -- this was an issue that pretty clearly cried out for -- for adjustment. That's, you know, based on our -- our mission of using science where there is science, and being claimant friendly where the science fails.

DR. MELIUS: What is the status of NCI finishing up IREP and getting reports out. I think you were expecting that several months ago.

MR. HENSHAW: Well, I mean I wish I knew, but I've heard, this is just by word of mouth, that they have another draft of their working report. I believe it was sent around for internal peer review in NCI early in December. I don't know where it is at this point or when they intend to release it beyond their internal review. I have not seen it myself.

DR. MELIUS: Go ahead.

MR. ELLIOTT: I think that some of the

changes that we have sponsored has triggered some revision in their working document, and they, of course, are going to have to get that explained and then cleared through the department. I know that the -- I think Mike Schaeffer is here from DTRA, but he may feel -- he may want to speak to this, but there's also between the Department of Health and Human Services where NIH and NCI is located, their -- this is their product to deliver to the VA for the VA's use. And until the VA's Advisory Board is reconstituted to review and advise the VA on the NCI/IREP, it will stay in -- in somewhat a limbo of draft until that is done, so -- and I don't know where they're at with regard to their establishment and reincarnation of their Advisory Board.

DR. MELIUS: What about, and this may be my memory also, but the NAS review of the report, was that underway also?

MR. ELLIOTT: The NAS review was finished, and they reacted and addressed all of the National Academy of Sciences comments. That was handled in the -- in a early version that you all saw, and I think -- I believe that part of their process is concluded. I'm not absolutely certain, but I think it has.

DR. MELIUS: I'm not sure exactly where we stand because we adopted IREP -- NIOSH has adopted IREP into its regulations, correct? Am I correct in terms of -- what did you adopt?

MR. ELLIOTT: We have a NIOSH/IREP. And it is what it is as it stands. It's based upon the NCI work and version, and we collaborated with them. We certainly, again, have made and sponsored some changes that they have thought through and adopted as well, but the -- you know, the NIOSH/IREP is approved, it is a department commitment and it's there for use, and it, you know, it was reviewed by you all. It stands to be revised with substantial modifications, and there's a process that -- that will support that. The Advisory Board needs to address substantial modifications in a review and a public comment period and provide recommendation to the Secretary on such modifications. We don't think this is a substantial modification, we think this is just a fix, and we would like to proceed with this fix. We've presented it to you twice, once in October and now again, with what we think is a logical and appropriate claim-favorable attempt to correct these two cancer risk models in IREP. We have at least, I know of one leukemia claim that's

pending resolution of this fix.

DR. ZIEMER: You may recall that we had the discussion in October as to what the Board's role was even on this matter, it was the issue of does this rise to the level of -- of being substantive or not. In either case, it certainly would not be inappropriate for the Board to indicate its reaction if it wishes to -- if I might use the word "bless this fix" or "curse this fix." We certainly have that opportunity. And I think certainly the staff will be quite open to hearing feedback from the Board as to how you react to this particular proposed adjustment to the model.

And Wanda, do you have a comment?

MS. MUNN: I guess my sense is that given our -- our prior commitment to being claimant friendly, that one probably can support the new suggestions that are being made. I think we need to make very clear what the discussion just was: That the science really does not support what we are saying here. I have concerns that once these types of assumptions are made, are quantified, and put in a table somewhere, that they end up showing up in courts of law with attorneys arguing that this body has found this to be true, when in point of fact, I

don't think what we're saying is this is true. I think what we're saying is this is our attempt to try to be as conservative on behalf of the claimants as we possibly can. Now, I don't know quite how we can differentiate that and -- and make that clear, but it does bother me if we can't point directly to the science and say this is what we've got.

DR. ZIEMER: That's certainly an appropriate comment. I think we also can make the comment that the science did not support the old model either, so either one is equally weak in that area, so it comes down to what is a reasonable approach. This seems to be reasonable in light of how we're handling the other risk coefficients and the other -- I'm searching for the right word -- it's the latency period, I guess is what we're talking about.

Okay, Jim.

DR. MELIUS: Yeah, just to follow up. I agree with what you just said, Dr. Ziemer, but also, this is not in response to Wanda's comment. For better or worse, IREP with sort of the mathematical modeling and the dealing with uncertainty serve -- in a lot of areas there's compromise and it ends up in between what may be, you know, weighing things, so I'm not sure we're really endorsing one science

versus another, it's a way of saying -- it's a way of capturing the uncertainty that is there, or the lack of data, or lack of certainty about that, and to me it's an appropriate adjustment for that. I'm not saying one way or the other on how this would, you know, it's not a yes or a no on some things, it's a way of compromising in the middle, not the way we're used to doing it either, which makes it a little bit more difficult.

DR. ZIEMER: Gen.

DR. ROESSLER: Well, I agree it's claimant friendly, but I think there is some science to looking at this new approach because things don't just end or begin at two years. There's biological variation, and I think there's a scientific reason for doing it this way, so I don't think it's, you know, I think it's a very reasonable approach, plus it matches with the other cancer models. And I think the whole thing's consistent and I frankly think the Board has every reason to say they should go with it.

MS. MUNN: Yeah.

DR. ANDRADE: I would just like to add my support to the statements and to the concerns that Wanda expressed. I believe that indeed there is

biological variation, and we're going to see cases that span a distribution of latency periods; however, I don't believe the science, even up to BEIR VII, is such that one can make any sort of definitive statement that the science is there, or that the uncertainty is small enough that we feel very confident in this. And I really support the idea of somehow putting into the record, perhaps even into any new legislation that arrives or that is sponsored, or that we help support, the fact that we are dealing with basically a compassionate approach and that at this point in time decisions made in favor, if this Board does choose to support this model, are being done so with that philosophy in mind, and that is all.

DR. ZIEMER: Larry.

MR. ELLIOTT: Thank you. I appreciate hearing these thoughts, and I think there's one way we can get at what you're asking for, Dr. Andrade, and that is to add something to a paragraph or two, or a section to the technical documentation for IREP. You recall we have technical documentation, it's on our web site. You've all been given a copy of it. I think we perhaps need to go into that and account for these kind of changes or these kind of

fixes and show where we're compassionate. We need to speak about, you know, where we become claimant favorable and friendly because science doesn't afford any further opportunity of its use, so maybe that's where we can locate this, in the technical documentation.

DR. ZIEMER: Okay. Russ, I think you can proceed. You have a couple additional slides.

MR. HENSHAW: On this issue I just want to add that we -- we considered this from the beginning a -- this particular change to fall under the category of administrative policy, and not -- there's no pretention that we're prepping new science here, so.

But anyway, moving on to a few other issues, we'll focus on three topics for the remainder of this presentation. The first, the recent revision of our NIOSH/IREP User's Guide; second, brief changes -- a summary of changes made to the software since April of 2002, and the reason it's April 2002 is that's when the first NIOSH/IREP User's Guide was distributed to the Department of Labor claims examiners and staff; and finally, discussion of scientific research issues. And I had the pleasure of reading, by the way, the IREP Workgroup's slides

last night, and I think we're pretty much on the same page there. There are a few differences, but I think we're all moving in the same direction anyway.

But going on first to the NIOSH/IREP User's Guide -- incidentally, we Fed-Exed a copy of this to each Board member last Thursday. Did anyone not receive the User's Guide?

MR. PRESLEY: I haven't gotten one.

MR. HENSHAW: You didn't get it?

MR. PRESLEY: (Shakes head negatively.)

MR. HENSHAW: If you -- when you get home, if it's not there, would you, you know, let us know and we'll get you another copy. Get another copy to you.

I don't know if you've had a chance to look this over or not, but I should mention it's designed really specifically for the Department of Labor for use by their claims examiners in adjudicating claims, although I think it probably could be helpful to other users as well. But the major changes are expanded glossary, we talk about the file-naming convention, and that's simply the file-naming I'm referring to the Excel template files that NIOSH sends to DOL, which abstract the dose reconstruction and provide the inputs for IREP.

We go into a much greater detail on how -- how to deal with multiple cancer claims, and claims requiring more than what IREP run. The User's Guide has some new screenshots which hopefully -- hopefully make it more user friendly.

And I might add, I'm not sure -- we talked about this briefly, but Larry, are we going to post this at some point on our web site, the User's Guide, or provide it with some other means of making it available?

MR. ELLIOTT: I must have been asleep at that point in time. Certainly we can. We can put this up there. Of course, there's, you know, the diskette that we provide, that would perhaps not be amenable to put on the web site, I don't know, but, yeah, we can put it on the web site.

MR. HENSHAW: Okay, moving on. Really, just about all the -- all of the changes made to the software since April have fallen into the category of User Interface Changes. We have a new opening screen that allows the user to, you know, choose one of two buttons, one goes -- one leads to a set of manual inputs, the other leads to use of the Excel template file. We now have a -- a random seed number generator function, that's in the advanced

feature section. Formerly, we were expecting people to use a random number table or some other generator to do that, and that seemed unrealistic, so we have that incorporated into the software now. And incidentally, the way IREP works, on this random number seed is the same random number seed for the same set of inputs will always produce the same probability of causation result. IREP uses an algorithm that, you know, accomplishes that. I think it's called a mark-all-chain, statistical terminology.

By the way, this is an aside, this just occurred to me recently. The word "algorithm" is in one sense an oxymoron. I don't know if you've thought about this, but think about it: Algorithm, Al Gore Rithm.

We also have the -- we have an online multiple primary cancers calculation button now, and fields to enter results from the different, separate primary runs. Before that, the Department of Labor claims examiners had to plug results into a mathematical equation. And a work in progress, it should be set up hopefully within the next couple of weeks, is to provide online links to the NIOSH/IREP technical documentation from the software.

Okay. On to a more important topic, I believe, the issue of scientific research and what's needed. Of course, you know IREP is derived from a set of radio -- excuse me, a set of tables and cancer risk models and methodologies first introduced in 1985. And our version of IREP was created under the time restraints -- under the time constraints imposed by EEOICPA and was never intended to be a stationary product. It was recognized from the beginning that more research is needed, and that changes should be made as appropriate as time moves on. I believe we're at that phase of the program now, and I think the beginning of that was the proposed changes for the leukemia and thyroid latency, but there are a lot more issues that we need to deal with and more issues of more substance.

I have a list of research needs that should not be construed as complete, nor are they in any priority order. These are topics that I just compiled from -- from discussions, and e-mail exchanges, and from Mary Schubauer-Berigan's original work over the past year. I just tried to give a thumbnail sketch of some of what we feel is important to -- to focus on. As I mentioned

earlier, I think many of these, if not most of them, are also on your list and I think you have one or two items that I did not include here. I did not use your list, the Board, the IREP -- using the IREP workgroup's list in constructing this one, but I'm -- I'm pleased that they're very similar. So this is really just a partial list, I guess. I think everyone agrees that DOE Occupational Studies need to have more of a presence in IREP risk modeling. That's -- that's number one on the list. I think we also need to look again at the -- our transfer model as the risk coefficients of transferring the Japanese cohort experience to our workforce. Age at exposure is a very important issue, and that's -- that's a multi-faceted issue. We also, at some point, whenever it's appropriate, then we need to, I think, update cancer incidence rates. Smoking and lung cancer is an often-raised issue, and again, that's multi-faceted. Some of the things that we need to consider regarding the smoking adjustment are -- are smoking categories, the definitions of our categories, and what constitutes a nonsmoker, and at what point -- how many years must pass after a person quits smoking before he or she can be considered a nonsmoker, or close to a nonsmoker.

Right now we have a former smoker category. There's a lot of work to be done with smoking and lung cancer, I think. Also, the race/ethnicity issue, the adjustment for skin cancer. And perhaps the large -- one of the largest, if not the largest sources of uncertainty in our risk modeling, the DDREF adjustment. And I mention, I think on your list you have CLL and other leukemias, probably so, I just -- I list only Chronic Lymphocytic Leukemia here because, as you know, it's the only cancer that's excluded from compensation, and I think we should reevaluate that.

The last item on this list has to do with interactions with workplace exposures, chemicals. I think that, frankly, will be very difficult to adjust for. I don't -- I'm not sure how realistic it is to do anything with that in the near future, but I think we're all certainly receptive to considering it anyway.

I might add also, NCI just within the past month has begun looking at the latency reduction function for bone cancer. Their thinking is that -- well, let me back up. Right now the IREP -- NCI/IREP and NIOSH/IREP use a latency reduction function for bone cancer that's similar to other

solid tumors which provides a midpoint, and I think it's 7.5 -- it's 7 or 7.5 years. Their thinking is that bone cancer more closely models thyroid cancer, and I -- I expect to hear that -- some announcement at some point that they -- that they will be changing that, so -- so we need to put that on the list as well.

I'd certainly be happy to hear any questions or comments on this, but I just want to say that we really look forward to working with the Board and with the IREP workgroup to come up with a design for research that really addresses the needs of the workforce covered by EEOICPA, so I think we have a lot of work to do.

DR. ZIEMER: A comment or question from Dr. Roessler.

DR. ROESSLER: I think, unless I fell asleep, you skipped over the BEIR VII line in your slide, and I'm wondering, it seems that BEIR VII should, or will cover a number of things that you have on this slide, and I'm wondering what is the status, is it out officially, or have you at least had a preliminary copy so you can anticipate what your work might be?

MR. HENSHAW: The answer to those questions

are, I think, no, no, and no. I -- I do not have a copy of it. I don't know -- I haven't heard any status report on it, and I don't know, maybe Larry knows something that I don't.

MR. ELLIOTT: I think the BEIR VII Committee is still under its deliberations. They're still working through. I've been trying to find out whether or not they have meetings scheduled for -- for this upcoming year. I'm sure they do, but I've been unable to determine that at this point.

MR. HENSHAW: To your question about whether BEIR VII will address many of these issues or resolve many of these issues, yeah, I think that will address most of these issues, and certainly it could be a starting point for our reevaluations.

DR. ZIEMER: My understanding is that BEIR VII is basically complete except for the fact that the Japanese dosimetry is being redone, and those risk coefficients may change slightly, so basically as soon as RERF comes out with -- or actually it's a separate task group, it's a dosimetry task group, comes out with their new information, which is supposed to be this spring, then it's plugged and chugged into a couple of tables in BEIR VII and they're ready to go, is my understanding. But then

you realize that in the National Academy's process, then there's this whole layer of review, and I know on BEIR VI there was over a year between the completion of the report and the getting it on the street, so whatever represents a fast track for the Academy is going to be something like that.

MR. HENSHAW: I gather also that there is some controversy about how it's going to shake out in terms of providing support for more claimant-friendly approaches, or less claimant-friendly approaches in IREP, so we'll just have to wait and see.

I might, one thing I just thought of is the comment on the smoking adjustment in IREP. One of the things I hear and I think it's a misconception. One of the things I hear from time to time is we should just throw out the smoking adjustment. We can't really do that, even if we wanted to, it would not be fair to anyone because the risk model is based on the Japanese cohort who were considered to have been moderate smokers, thus the adjustment goes -- the smoking adjustment goes both ways at IREP. If we were to simply remove it, that would not be fair to nonsmokers because they're in effect penalized by the heavier smoking experience of the

Japanese cohort, so it's a very complicated issue, it does not lend itself to an easy fix.

DR. ZIEMER: Any other questions for Russ?

Thank you very much, Russ.

We're going to take a break in a moment. I do want to point out to the Board that if you do wish to take any formal action relative to the fixes that -- that NIOSH is intending, it certainly is not inappropriate to do so; that is, you can endorse them or as I said, you can bless them, curse them, or ignore them. And I -- I would say from where I sit it would not be inappropriate if you -- if you would like to go on record to actually propose a motion that would say in effect the Board is in agreement with the proposed fixes and endorses them.

Tony.

DR. ANDRADE: I certainly would like to be able to propose a motion; however, you know, previous -- in previous discussion with Larry, he mentioned that we might be able to address the quick fixes insofar as our consensus as to how we feel about these and -- and the fact that perhaps in some cases we are being claimant friendly, or in some cases we are adopting them because new science points out that we should. And Larry mentioned that

we could include this type of information in technical documentation, so I wanted to ask for perhaps a little bit more clarification.

Larry, were you talking about technical documentation such as the IREP, what do you call it, Guide, or some other form of documentation?

MR. ELLIOTT: I was referring to the technical documentation that supports the cancer risk models in IREP, not this User's Guide that Russ sent out to you by Fed-Ex last week, or you've seen in the past. I think that we can simply put a new section into that technical documentation titled Administrative Policies, perhaps. And there we can account for where science doesn't serve us well anymore and we need to take a claimant-favorable approach, and we can outline how that approach is claimant favorable.

DR. ANDRADE: So what you're proposing is a new --

MR. ELLIOTT: New section or -- or something to the -- it's been a while since I've looked at the technical documentation. I recall it being, you know, it has different sections in it; it talks about different cancer risk models; it talks about the transfer issue from Japanese survivor experience

to the American workforce. I think we can add a new section to that that talks about administrative policies.

DR. NETON: Larry, if I could just add to that that this is very consistent with the current IREP documentation that exists where every cancer model that we've adopted has a fairly detailed discussion as to the science behind it and where we were claimant favorable. We were very careful to point that out because the science could not support any other model. So I really think that this would just be a modification to the leukemia discussion of the risk models in the IREP documentation now, and we would just be consistent with our past approach.

All of our models have these type of discussions about whether they're based on pure science or the lack of science, you know, but will be claimant favorable. I think that's the appropriate place to do that.

DR. ZIEMER: I also don't want to necessarily have a precedent that every minor change in IREP requires Board action. I'm simply reminding you that there was some uncertainty last time as to whether this particular item reached the level that would require Board action, and one thing that could

be done that's somewhat in between would be simply to go on record indicating that, for example, there's no objections, or that the Board is in agreement with this change, or has no problem with it, something like that.

Roy.

MR. DeHART: Yes. I think the -- I would like to see the Board agree that the changes that are recommended for the leukemia/thyroid model is consistent.

DR. ZIEMER: Are you making some sort of a motion, or is this --

MR. DeHART: I can make a motion --

DR. ZIEMER: -- just an observation?

MR. DeHART: -- of that if you wish. It was an observation primarily that they are making these changes to be consistent to the other models that they had.

DR. ZIEMER: Anyone else wish to comment, or?

DR. MELIUS: Only the fact that I -- I think we probably should make it a simple motion. I don't disagree with what Roy just proposed, but I'm afraid we can get -- we can spend a long time trying to figure out the exact wording to justify this and to

reflect the diversity on the Board, and I would think it's maybe just better if we just try to something straightforward.

DR. ZIEMER: Well, for example, a motion that said the Board is in agreement with the proposed fixes in the latency adjustment for leukemia and thyroid, and has no objections to their being implemented.

MR. DeHART: (Raises hand.)

DR. ZIEMER: Did somebody move that?

MR. DeHART: I moved it.

DR. ZIEMER: That was what Roy was intending to say. Actually, it's a very unsanitary way of speaking, it's putting words into other's people's mouths, but --

WRITER/EDITOR: The motion was made by Roy?

DR. DeHART: Yes, Dr. DeHart.

WRITER/EDITOR: Thank you.

DR. MELIUS: I'll second the motion.

DR. ZIEMER: And this is intended that this be a motion of general agreement, not -- Wanda, you have a comment?

MS. MUNN: I really would like to add to that the kind of caveat that Larry just indicated, that the rationale --

DR. ZIEMER: And the Board -- and the Board, for the record, recommends that the --

MS. MUNN: That the --

DR. ZIEMER: -- staff clearly specify the reasons for these adjustments --

MS. MUNN: Right.

DR. ZIEMER: -- in the documentation. That was part of your original motion, was it not?

MR. DeHART: That was the amendment to my motion.

MS. MUNN: Thank you for that unsanitary amendment.

DR. ZIEMER: An extremely -- an extremely friendly amendment.

DR. ANDRADE: I second that one.

DR. ZIEMER: Well, that was not a motion, it was a friendly amendment we had already agreed to. Now, I -- I don't want to presume that this is -- are there comments on -- I'm trying to develop the sense of the Board here very quickly because everybody is wanting a break, which is the best time to have motions, actually.

DR. ANDRADE: Exactly. Paul, I think it's extremely important and I'll reiterate that down the -- down the years, in the years that follow that

people -- it is important for people to understand that we're not endorsing the science that currently exists, and that it not be used as a basis for say, legislative -- legal action, and that sort of thing. I think it's extremely important that we at least put in the phrase that we are endorsing this as a result of, or following the compassionate philosophy.

DR. ZIEMER: So the motion would really read: The Board is in agreement with the proposed fixes in the latency adjustments for leukemia and cancer and endorses the changes presented as a means of incorporating a compassionate --

MR. GRIFFON: I just -- I'm reflecting back on what Dr. Melius said about we can end up with a complicated motion here instead of a very simple, because I think I'd add --

DR. ZIEMER: It's going to be less and less simple.

MR. GRIFFON: -- I think what we've heard around the committee here is that it's not only the compassionate, it's also the uncertainty of the science, so I think that there's kind of two sides going on there. And I think we're just -- I was in agreement with the first motion with all this other

stuff understood, you know.

DR. ZIEMER: Okay. We'll go with the motion as it was originally -- is that -- everybody understands that?

MR. ESPINOSA: Can you repeat it?

DR. ZIEMER: The motion is the Board is in agreement with the proposed fixes in the latency adjustments for leukemia and thyroid, and endorses the -- or, let's see -- and endorses the changes as presented. The Board further recommends that the documentation specify the reasons for the changes.

MR. ESPINOSA: I'm all right with that.

DR. ZIEMER: Okay. Are you ready to vote on this? All in favor of the motion, say Aye.

BOARD MEMBERS: Aye.

DR. ZIEMER: Any opposed, say no.

(No response.)

DR. ZIEMER: Any abstaining?

(No response.)

DR. ZIEMER: The motion carries. Thank you very much. We are going to have a 15-minute recess.

(Whereupon, a recess was taken.)

BY DR. ZIEMER: (Resuming)

You may recall that Jim Melius was the Chairperson for our Working Group on IREP issues,

and he's going to present the report. We actually distributed a draft of this report at our last meeting I believe, at the end of the meeting.

DR. MELIUS: And the draft hasn't changed.

DR. ZIEMER: And the draft hasn't changed. Give us an update and some additional comments, Jim.

DR. MELIUS: The workgroup -- which was myself, Henry Anderson, and Leon -- I'm the only person that made it here today, so I can now report that all of our conclusions were unanimous and no one will disagree -- seriously -- was charged with looking at the issue of how do we set up a review process for looking at dealing with IREP and other scientific issues that have come up or may come up in dealing with the -- this overall claims processing, and dose reconstruction in particular. And also to come up with a process for -- some recommendations in terms of what might be some priority topics, and then also related to that was -- was also the issue of consistency with some of the other radiation compensation programs.

So in doing that we sort of, you know, consider what would be some of the reasons for wanting to bring things up for review. And clearly, it would be that there's some limitation or some

problem with -- of the science that was being used for IREP models or some of the other models used in dose reconstruction. In looking at this, most of the time these limitations are usually related to, not to the model itself, it's not a problem with the scientific model we used, but -- but often with its applicability to this particular group of workers, or to this particular situation. And certainly, you know, and we know that, for example, IREP is based for the most part on atomic bomb survivor data, and so how applicable is that. Some of the dose reconstruction ICRP models are -- are based more on -- on dealing with worker protection issues, and so it may not have considered, or some of the assumptions used may not -- may not always be appropriate for certain cases that might come up in -- in this program. So it's not always a question necessarily of the basic model involved or models, but rather, either the limitations of the applicability of those or limitations due to some of the assumptions, the situation being different for here.

We also may want to review the science to try to improve -- make some improvements to IREP or the other model used for this application, so this

is the obvious issue of applicability or assumptions, but rather that, look, there are issues there; and again, an example being would come up that we know there's limitations to that science, what can -- there are now some new data out or new information out that would allow us to -- to make changes in this and that.

We also want to provide, I think, some level of consistency, or at least be able to address inconsistencies that might occur between the IREP application and other model applications used for this program compared to some of the other compensation programs. And I think the smoking example that came up earlier would be one example that some of the other ongoing changes going on at IREP that, as it's being developed for the VA program may also raise some questions of inconsistency, and while there's no requirement that the programs be -- all be consistent, I think there could be times when those inconsistencies should at least be explained or addressed in some way. Now, some of the inconsistencies may come out of the legislation, so we can't -- can't directly address that here, but.

Finally, there may be -- we may want to

bring up scientific issues because there's some sort of a perceived problem. The claimants feel that the model is being applied to them and their dose reconstruction is not fair to them, is the perception. And that -- and us, as a committee, and NIOSH in trying to respond to those concerns, would we want to review a certain part of the model. That review may very well affirm what's being done, but it would at least allow some public discussion, and review of -- of what is perceived to be some unfairness in either -- let's say in the model itself, the basis that's used for dose reconstruction that's underway.

I came up with a -- we came up with a list of topics that were based on -- I went -- actually, I went back through some of the earlier comments that came in on IREP and the dose reconstruction procedures, went back through some of the peer review comments that had been submitted. There were some issues that came up, either from the Board or from the public comments as the Board was in the process of reviewing IREP and reviewing the dose reconstruction procedures, and a few that I believe had come up in later Board -- Board meetings. So it's not necessarily meant to be an exhaustive list,

but I think it -- I think it does at least capture the ones we had already talked about, or had already -- at least there was some issue about. In fact, I think on some of these we, when at the time we adopted the NIOSH -- NIOSH/IREP, we specifically pointed out that these topics need to be discussed in more detail at a later point in time, or reviewed in more detail at a later point in time, so -- and many of them I think were issues that NCI, NIOSH, everybody sort of grappled with already, and now are pretty well known and so forth, and -- but, you know, as part of this program we had talked about, or it had been brought up as something that might be -- might be discussed. This is not a prioritized list, it's not a comprehensive list, and it may change over time; to some extent it's changed already. Someplace on the list is leukemia, the latency for leukemia and thyroid, and so I think we've gone beyond that now, that list. And, as I said, these are some of the same issues that Russ brought up, so it's the smoking adjustment came up for lung, and also could come up for other cancers; this whole issue of age at exposure and survivor -- survivor population, incorporation of occupational studies. It's not the issue of interaction

necessarily with the chemical or other toxic exposures in the workplace, but rather the -- the -- the issue of how do we, or should we take into account, or IREP take into account some of the occupational health cohort, those issues of comparison population and -- and so forth with that, and -- and there's actually some, I believe, in the legislation itself that actually doesn't require that, but certainly promotes the idea that that -- the fact that these are of occupational cohort ought to be taken into account. The issue of CLL and other leukemias, and this is an issue both of -- I think it came from legislation, CLL, but as much as the fact that our classification of leukemias is changing, and our understanding of leukemias is changing, and how do we properly take that into account in -- in this compensation process.

Again, this issue with the occupational cohorts as well as the difference between the Japanese population and -- and here in terms of incorporation of background cancer risks, there's some issues that came up in terms of how should some of the less common types of cancers be grouped in this process, and is that grouping -- current grouping appropriate, need to be changed. The whole

issue of dose rate over the DDREF adjustment, which we actually discussed at an earlier meeting was a subject of some of the peer review that NIOSH had, it took place for earlier in the development of the regulations and so forth with that.

And those are, I think -- I think is a fairly comprehensive list of the issues that we had discussed or had been brought up -- brought up to the Board at the time.

Now, what we talked about in terms of a -- of a process for doing this, a recommended process for doing this is, one, we need to prioritize the topics; what does it make sense to do, what's an appropriate schedule for -- for dealing with -- with some of these, and then some of them we may very well say are things that are a few years down the road, or if ever could be dealt with. Then, much as they did for the thyroid and leukemia, I think the NIOSH staff or contractor staff, however they want to do it, would prepare a background briefing that would include -- could include recommended changes, could just review the science and so forth, but that -- or policy options that might be considered -- that report would go out for some sort of outside peer review or consultation, and that consultation

may be with agencies like NCI and so forth, the peer review may be various outside scientists, so there would be a record of -- of that process and so forth. That review, and the NIOSH report, and any changes to that report as a result of the outside review would come back to the Board, be presented to the Board by NIOSH with whatever consultants that do it. If there's a diversity of opinions on that issue, then I think -- I think it's helpful to have some of those different views presented to the Board, so we -- we hear about them.

And based on that, the Board would make a -- make a recommendation. Now, we really -- I didn't really try to get into this -- the working group didn't look at the issue of what's a significant change or not because the recommendation might come back that after the review of the issue we may say there ought to be some insignificant modifications made, or ones that wouldn't sort of cross the threshold of requiring, you know, *Federal Register* notice and so forth. But the Board would make a recommendation to that effect, a decision as to whether or not then to go forward and with a, you know, the formal *Federal Register* process, invite, you know, the general public to review the change

that's being made, if there is any change, and then it would come back -- as much as we deal with other regulations and so forth, come back with a final set of recommendations based on what that peer review show.

I think that -- those steps -- now, it may be that the Board makes a recommendation that no change should be made at all, so I think that obviates the next steps. It may -- this also, I think is a fairly fluid -- it would be a fairly fluid process and it may be that, look, the science isn't there or we need to wait and see what BEIR VII does, or some other -- other particular study or something that -- that -- that would come out -- come out and we'd address this particular issue. There may be ongoing research or whatever, so -- so there is some -- it's not always just, you know, straightforward step wise, and as I said earlier, some of these topics may require a longer period of time. And I think it's also going to serve an overall issue of what -- which NIOSH and Larry and his staff have started with, was -- is they are learning in this process and coming across situations; at what point do they develop a new procedure, how much is, you know, how big a change

is that; to what extent do they want the Board involved in that review, and so there may be sort of different relegations of review, but I tried to sketch out what would be, I think, the -- the complete one. I think the key things, we're -- you know, we're not an expert committee in that we have -- that we really have a formal straightforward peer review process to come back to, you know, capture what opinions are -- are out there with the appropriate scientists, and then the Board would have a chance to reflect on that in terms of a change in IREP, or other -- or other procedures that are underway. Let me stop there.

DR. ZIEMER: Thanks, Jim. Why don't you -- you can go ahead and return to your seat if you want to handle questions from there, but let's see if there's any questions first, or items that need clarification. This actually is a workgroup recommendation, so we will need to take some action. But let's get the questions on the floor for comments or clarification, or whatever. Any?

Okay. There's a couple possible routes of proceeding on this -- there's really two things. There is some recommended processes here, and then there are some possible topics which, if we, in

essence, say that we agree or adopt the report of the workgroup, which means we are in agreement that we should have a process such as the one described. The first part of that is taking the topics and prioritizing them. There's no since prioritizing the topics unless we agree that we want to do something along the lines of what is described, either exactly along these lines, or approximately along these lines. And I -- I think it would be appropriate since this is a report from the working group that we can regard it as a proposed action that the Board adopt this as a -- as a process for dealing with IREP as we move forward. And at the moment, unless I hear objections, I am going to interpret this as being a motion from the working group that we utilize the proposed process. Okay.

Now, Wanda.

MS. MUNN: I guess perhaps I missed the introductory comments, which make it a little difficult for me to be very sure exactly what we're recommending here. I thought I was following the effort of the workgroup and what had transpired, but I'm not clear exactly what the workgroup is asking us to authorize.

DR. ZIEMER: Let me partially answer that,

and then Jim can really clarify it. But this whole thing arose when we said, you know, there are a number of issues with IREP that may need clarification. And let's take, for example, the one we discussed this morning which had to do with latency period.

MS. MUNN: I recall that.

DR. ZIEMER: What this process says is let's identify those areas of IREP where we may have ongoing concerns, or future concerns, and then if we want to learn more -- we prioritize those and say which are the most important ones for us to address. Once we do that, we ask the staff to help us identify people that can be brought in to address those issues, and then based on what we hear, we would say well, we should do something, or we shouldn't do anything, or whatever. In other words, it's -- it's -- I would see it as an ongoing effort to assure ourselves that IREP remains current with both the science and other related issues.

Now, Jim, help clarify.

DR. MELIUS: Yeah. And I think what -- we've wrestled with this as much as with a scheduling issue and a procedural issue. This is, you know, it's not a top priority, I think, for

Larry right now, or NIOSH, and I don't expect them to be to put out a whole bunch of *Federal Register* notices to make major changes in IREP, we're not expecting that. At that same time, there's been issues that have been raised that I, and I think other people on the committee have requested, or the Board, what should be addressed, so we're asking you to in some way hear some -- some presentations on those issues. It may -- may take some period of time and so forth to be brought up to date of where NIOSH stands with those, and so forth, and -- and so part of this came out just as a scheduling issue. Larry is trying to figure out how to schedule Board activities and so forth; what do we think are the important issues; and getting -- getting them into some sort of priority, so what I think what we're asking -- the working group is recommending is one, we look over issues, a list of issues, we prioritize them; we tell -- we recommend to NIOSH these are the most important issues they ought to be working on in this particular area. Larry then just has to, you know, obviously, balance those versus the other workload and available resources and all that. Number two, that the procedure would be that for NIOSH to do -- prepare a background report on that

issue; obtain peer review or outside consultation on it; and then come back to the Board with much as what really Russ has -- Russ has already done, with this is the problem; this is the science; this is the recommended, if any, policy change or IREP change that -- that would take place, or these are the options for that. The Board would then make a recommendation based on that of yes, you ought to go forward with that, like we -- in some ways like we did today; it's not a significant change, but, you know, in a sense of requiring *Federal Register* notice or whatever, or it is -- it is, this would be a major change, or you shouldn't make any change, this issue is just -- the science isn't there, and there's not enough difference in the science or change in science to warrant any change.

DR. ZIEMER: Keep in mind also, that this process will probably occur anyway. I mean the staff is always looking at IREP and saying, you know, where does it need tweaking or improving or whatever. The point here is for us to be working in harmony with that, and also be able to say what are the items that we think -- telling the staff what we think are important, that may or may not be the same list that they have, but, you know, I think many of

these things would arise, but this makes it less sort of random and makes it a little more focused in terms of what we think are the -- the big issues with IREP as we go forward.

But I don't -- I don't think it presumes, at this point, any particular items, nor any particular schedule, but as we go forward with this, as we identify issues or as the staff does, they need to come forward in a -- in a sort of organized and prioritized manner.

DR. MELIUS: And if I could just add, and we have to recognize that the claimants are going to in some ways bring up issues that may need to be addressed, and this issue of the other radiation compensation programs because of inconsistencies or differences in policy that -- that would -- that -- say the VA adopts a different policy, then we may want to take a look at that cause, you know, that's certainly something that claimants or other people are going to bring up, so -- and always saying this is a process for doing that, it's a process that's based on peer review and, you know, expert consultation. I guess we're sort of being central to that, and then sort of a review of that by the Board after that period.

DR. ZIEMER: Gen.

MS. ROESSLER: My comments change as you talk because it becomes clearer. After you made your presentation, I wondered how the workgroup would change their approach after hearing Russ's presentation this morning because it seems like your list and his list are almost parallel, maybe with the exception of one item. So I think what I need at this point is for you to follow your recommendation and make a very simple statement as to -- it seems like we're doing all of this, but apparently you want it more formal.

DR. MELIUS: No, no.

MS. ROESSLER: No, I -- I don't know where we're going.

DR. MELIUS: No, I think we're begging sort of one question. I think the one thing that we need to do as a Board is prioritize that list in terms of what needs to be worked on in the nearer future as opposed to the greater future. Once we've done that, then consider that list in its prioritized, then we're recommending -- the workgroup is recommending a procedure for dealing with that, which is saying what Russ already -- some of what Russ already did was, you know, with the thyroid and

leukemia was did a review, you know, the background review; that background review is presented to the Board with someone outside peer review involved. The extent of that peer review, I think, is going to be dependent on the extent of the change, yeah, I mean I'm not faulting them for not having a more formal process for the thyroid and smoking, but -- excuse me, thyroid and leukemia latency issue. But the real work -- the real thing I think we need to do is -- is -- that would be helpful is the -- is the prioritization.

DR. ZIEMER: Larry.

MR. ELLIOTT: Let me remind the Board that the regulation on probability to ways -- how we determine probability of causation, which speaks to modifications of IREP Section 81.12(b). That rule allows the Board and other sources to recommend revisions to NIOSH/IREP for NIOSH consideration.

81.12(c) requires that NIOSH implement any -- that before NIOSH implements any revision of the NIOSH/IREP that would substantially affect estimates of probability of causation, NIOSH must obtain the review of the Board and address any Board recommendations arising from such review.

81.12(d) requires NIOSH to notify the public

through the relevant Board meeting notice of any substantial changes as defined above that NIOSH is proposing for the Board's consideration and to solicit public comment on such changes.

That's the formal process I referred to earlier where we have a substantial change that we would like to make or we propose to make. What we presented to you this morning and in October of last year were, we didn't feel, substantial changes; they were fixes to those cancer risk models to make them consistent with the others. This will be the formal process. Certainly we could, you know, as we announce the public meeting in the *Federal Register* notice, we would announce what the, you know, the substantive change would be, and how people could -- and the public could get copies of that proposed change for their review and comment.

And I -- I agree with Dr. Melius, what I'm seeking is some insight from the Board on what the Board thinks are priorities in this list. Certainly in my mind, in the next meeting or two we need to bring NIOSH staff from another branch of NIOSH, a research branch, who's been studying the DOE workforce for the last 10 to 11 years to give you a status report on the research studies, and what has

been completed to date, and what's underway, and how those research studies reflect upon the list that you've prepared, the list that we've prepared, and -- and that might be a good starting point to get a sense of -- of where things are at with regard to the DOE workforce, we may have a better sense of what BEIR VII's coming out at that point in time as well. So just for some background information, I want you to understand our regulation on probability of causation does prescribe a process here for us to use in making changing to IREP.

DR. ZIEMER: So this -- this process simply supplements that and just says --

DR. MELIUS: It's just the introduction.

DR. ZIEMER: -- what -- what are their priorities.

DR. MELIUS: Yeah, yeah.

DR. ZIEMER: Tony. Comment.

DR. ANDRADE: I, too, see this presentation as providing us with two -- two separate topics to deal with; one being the prioritization of topics that we would like to hear about, okay; and inherent to what I said, is the fact that this prioritization does not necessarily reflect any -- or necessarily any major changes to IREP. These are just simple

scientific discussions that may or may not warrant any further action, so that's number one. And I feel that prioritization is -- is a good thing to have, and perhaps other topics will come from NIOSH, they may come from the public, as Dr. Melius alluded to, etcetera.

The second, I view as a transparency issue. The process proposed here is something that we are doing already, and so to document it for the record would simply provide the public especially, at least an understanding of how we do review these topics, and that at any point in time, we may decide okay, well, this topic probably needs further attention, or may warrant further investigation. But at least this process will allow the public to know how it is that we discuss these things. And I -- and so again, I see it as a way to increase our transparency.

DR. ZIEMER: Other comments? Wanda.

MS. MUNN: I believe I heard, and I think I now understand, that prioritizing and establishing a list of potential concerns with IREP and prioritizing them would in no way constrain staff from the more immediate work that they have ongoing, and that would be a major concern for me; other than

that, I can see no reason why, with that understanding, that we shouldn't proceed with the prioritization and follow through with the processes already established in regulation.

DR. ZIEMER: Larry, is that?

MR. ELLIOTT: (Nods head affirmatively.)

DR. ZIEMER: Jim.

DR. MELIUS: Yeah, and I would just -- I may not have been clear on this, is that this is not sort of a fixed process that, you know, nine topics have to be dealt with in the next six months or something like that. Many of these -- these are issues that have been raised, they may not be appropriately or should not be appropriately addressed for some period of time, and it may be that it's something we want to hear about at a series of meetings. They're not simple issues, they're not going to be resolved in one meeting or one presentation, but that they would be resolved over -- over a period of time, so there would be some flexibility. At the same time, as Tony pointed out, it would be a transparent process, so if someone on the outside has questions, well, how come you're not -- you haven't considered changing this, or how come, you know, you're still, you haven't

addressed this, you know, my concern here or whatever. And you say well, there is a process; we're aware of that issue; there are reasons, you know, it takes time to deal with it and it may be reasons that's inappropriate to address that particular concern.

DR. ZIEMER: Any other comments?

What I'd like to do then is consider this a motion for the Board to accept the recommendation of the workgroup, and the implication of that, in turn, is that we would then proceed to try to prioritize the proposed list here. That would be the extent of it at the moment. If you vote in favor of this motion, it simply is to put on the record this general procedure -- I'm calling it general because it's -- it's not completely prescriptive, and then to proceed with making an attempt to do some early prioritization. Are you ready to vote, then, on this recommendation? Okay.

All those who favor the recommendation of the working group, please say Aye.

BOARD MEMBERS: Aye.

DR. ZIEMER: Those opposed, say no.

(No response.)

DR. ZIEMER: Any abstentions?

(No response.)

DR. ZIEMER: I'll declare the motion carried. It would then be appropriate, if we're able to, as a result of that to attempt some prioritization. We can do this -- there are eight topics that -- I believe there were eight on your list, Jim.

DR. MELIUS: Yeah. Really, seven now, cause thyroid we dealt with.

DR. ZIEMER: And we can either try to write those, or an option would be, for example, to say which two or three are the top priorities, you may not be able to rank them, and then, you know, high priority and lesser priority, you know. We could have one or two, or even three categories. Well, it's got to be more than one. They're all priority, aren't they?

But, Roy, you have a comment first?

MR. DeHART: Just a question. Is it appropriate to introduce any other priorities that the Board may have?

DR. ZIEMER: I would say yes. This is not -- in adopting this, this is a list that's called possible topics. It would be my understanding and the Chair will interpret it this way that this does

not preclude at any time adding additional items. And Jim, I think that would be the intent of the workgroup, as well.

DR. MELIUS: Yeah.

DR. ZIEMER: So.

MR. DeHART: With that statement, I would like to have the Board consider adding either now or later, but I think we're all going to have to be very familiar with the issue of prostate cancer because that's going to be a major issue as we deal with this older male population. And as you know, it is a low-risk cancer for radiation, and I think we're going to have to understand that and understand the current science of that, and have that in a form that the population at large will understand.

DR. ZIEMER: Is there any objection to adding prostate cancer issues to the list?

(No response.)

DR. ZIEMER: Without objection, that will be added. Any others?

(No response.)

DR. ZIEMER: Okay. The Chair is open now to having suggestions, and let's -- I'm not going to ask for a specific motion -- but let's see if we

develop any kind of consensus what people think are the top, oh, let's say three items, or your top item, whichever. Let's see how it develops.

Wanda, do you want to start us?

MS. MUNN: Well, it's my understanding, I think, from what Larry said that what I see is very possibly the best and first item, is already underway; you're already looking at the workforce population studies, and we're going to be getting that before very long anyway, so I would propose that we accept that as our first priority since it seems to be the most directly applicable to what we're here to do in any case.

DR. ZIEMER: I believe that's the bullet three, that's the incorporation of the occupational studies. I think those are the DOE studies that would be referred to.

And let's hear some reaction to that. Roy?

MR. DeHART: No, I would agree with that. I think those epidemiological studies are hard drivers.

DR. ZIEMER: Robert?

MR. PRESLEY: I couldn't agree with Wanda more.

DR. ZIEMER: You agree with that?

MR. PRESLEY: I agree.

DR. ZIEMER: Jim. Jim? Tony?

DR. ANDRADE: No comment.

DR. ZIEMER: Others? Okay. It appears that certainly that's in the high priority list then, the incorporation of occupational studies. I'm not even sure if that's the right set of words, but it's that issue. We understand what that means.

MR. ELLIOTT: We would start off by giving you a -- having this other research branch prepare a status presentation for you, that's the starting point. I think if you look at Russ's list, our interest is to evaluate those finished DOE studies and determine what has been learned from them that is applicable to compensation practice, you know, so I think that's the second step in -- in looking at. We need to first get you an understanding of what has transpired with those research studies, and from that I think will evolve, with your help, identification of which pieces do we need to look at a little further and evaluate for compensation practice and, you know, IREP risk cancer policy, those kinds of things.

DR. ZIEMER: Jim.

DR. MELIUS: Another suggestion, not

disagreeing with the other one, is item number one, this whole smoking issue. I think it's an issue of consistency with the -- with the VA program, as well as one that, as much as Roy talking about prostate cancer, I think it's one that's going to come up as a common concern on the part of claimants, and I think we ought to be addressing that also.

DR. ZIEMER: It might certainly be of value to know what studies are out there, and what the data show on -- on smoking. There's some -- some of the radon work has attempted to separate out smoking and radiation exposure to the lung.

DR. MELIUS: And there are also some -- I think that should also include some policy options on how to deal with it. There's issues with the classifications of smoking, as Russ brought up this morning, you know, former smokers, what -- what are the appropriate groups to be looking at, and what's an appropriate adjustment for taking that into account, so.

DR. ZIEMER: How do others feel on that one? Wanda.

MS. MUNN: Yes. But is this not incorporated in some way in what I see as something we ought to all be keeping very close track of, and

that is the base-line cancer data in the general population because that's -- that's one of the things that's on our list, and I guess in my view, the smoking issue is one that is actually a subset of this cancer data in the general population. If we don't look at it in that way, then we immediately get into the issue of additive effects, which is going to be thorny at less -- at best, and insoluble at worst, and I guess I'm not arguing which should come first, the chicken or the egg, it's just that I see them as so closely related that the issues which is --

DR. ZIEMER: We need to understand exactly how smoking is dealt with in terms of both the controls and the -- and the population, for example, the Japanese data versus cancer incidence in the U.S.

DR. MELIUS: Can I just say, and I think the topics are two and five; five the background, and two the survivor population issues there are both sort of going to come up all the time. They're going to come up also with the occupational issues also; what's the appropriate comparisons, so I -- and I think those may be in some ways appropriate, not only to -- and they have to be -- they should be

addressed with those, but also to serve as some of a background, they will be hearing more about those issues and in general, not necessarily having to take action on them directly, but maybe doing so in terms of smoking and occupation.

DR. ZIEMER: By five, you're talking about incorporation of background cancer risks?

DR. MELIUS: Yeah, yeah.

DR. ZIEMER: Roy.

MR. DeHART: Yes, I'd like to move back with the smokers. I think as we all know, lung cancer is the number one cancer killer now among both male and female populations, consequently we're going to see a lot of lung cancer. And the population we're dealing with, the estimated number of smokers, past smokers, are going to be running between 40 and 50 percent, so when we compare that to the number of lung cancers we're going to have, this is going to be a major issue, and I think we really need to know the science on this.

DR. ZIEMER: There seem to be nods of approval, so we can consider that as a high priority item. For the time being we're calling that maybe second.

MR. GRIFFON: I was grouping those as one.

DR. ZIEMER: Priority one -- priority one. I'm wondering if it wouldn't be helpful to identify at least one third one and call that, you know, talk about our top three as priority one items, so we don't get into details on language.

Robert, do you have a --

MR. PRESLEY: Number six, miscellaneous cancers.

WRITER/EDITOR: Use the mike, please.

MR. PRESLEY: Number six, miscellaneous cancers. Should we not go ahead and start looking a little bit more at that before it gets -- bites us down the road?

DR. ZIEMER: Is that the one -- excuse me, for clarification on the slide, is that the one that is --

MR. PRESLEY: The rare cancers.

DR. ZIEMER: -- the rare cancers.

DR. MELIUS: There's issues of grouping, as well as what's been created and so forth, and so there's, I think, some sort of technical issues that come up with that.

DR. ZIEMER: Robert, so you were suggesting that that be --

MR. PRESLEY: Yes.

DR. ZIEMER: Others, comments on that? Or if you have something else you think is a higher priority you can say something.

Yeah, Richard.

MR. ESPINOSA: I'm not necessarily -- I'm not necessarily in disagreement, but I do think age at exposure probably should be within the top three or four.

DR. ZIEMER: Okay. Thank you. Mark?

MR. GRIFFON: I guess I was just going to -- the three I have was the smoking, the incorporation of the background cancer risk -- and I think Wanda and --

DR. ZIEMER: To some extent that gets linked with the smoking, so.

MR. GRIFFON: Right. And then the worker studies, those three grouping within one level.

DR. ZIEMER: Any other comments? Let me suggest the following to speed this up a little bit, so. Kind of link smoking and incorporation of background together as a kind of a combined topic, so the age at -- I'm sorry, the incorporation of occupational studies number one; the smoking and background cancer risks are the second one in the group, not necessarily in rank, but top priority;

and the rare or miscellaneous cancers the third one in that group; and then the only other one that's been mentioned is the age at exposure. Do you want to include that in the top list or --

DR. MELIUS: Only in that I think that takes some time to get briefed on and developed and so forth, and I think -- I think it's important to start on it. I don't think we necessarily expect to resolve anything with that, whereas maybe with some of these others will be.

DR. ZIEMER: Perhaps we can agree that maybe that one would be the top of the second priority of --

MR. ESPINOSA: That's fine.

DR. ZIEMER: Is it agreeable right now to have first priority and second priority, and have those -- those first three topics, and then we put this next one at the top of the second priority? I'm not sure it's useful for us to try to rank things in any more detail beyond that. We have the list and we can always revisit it at some point if something rises to the top, we just identify that and say let's go ahead and look at this. There's no real value spending much more time on it.

DR. MELIUS: Bob just made a good point on

the BEIR VII like at the age of exposure, the survival -- all the -- I think BEIR VII may address that issue to some extent. We certainly will be waiting for BEIR VII before we address this.

DR. ZIEMER: Right. Roy.

MR. DeHART: Yes, I'd like to suggest if we're doing a second priority that we put prostate in there because --

DR. ZIEMER: Oh, I'm sorry.

MR. DeHART: -- I don't want it to wait too far down the line.

DR. ZIEMER: Right.

DR. ANDRADE: Paul?

DR. ZIEMER: Yeah.

DR. ANDRADE: I was going to suggest that we include prostate cancer as part of the miscellaneous cancer group. That goes up in the first priority.

DR. ZIEMER: Yeah, because the rare types of cancer --

DR. MELIUS: That's --

DR. ZIEMER: -- no, for radiation, what's considered for radiation on that perspective. So we'll agree that prostate is in that category. Thank you.

Is there -- Wanda, please.

MS. MUNN: We might keep in mind that with the current emphasis on understanding and treating prostate cancer in the general population, we probably will get a great deal of basic information on that when we get base-line data as well.

DR. ZIEMER: And these are not all mutually exclusive --

MS. MUNN: No.

DR. ZIEMER: -- and there will be overlap, I'm sure, in any event. So can we pretty much agree on these without a formal vote that these will be our priorities for the moment?

MS. MUNN: Yeah.

DR. ZIEMER: I think we came to agreement on that. Thank you, Jim, and our working group for -- for your work on that particular item.

We're going to break in just a few moments.

MR. ELLIOTT: At the risk of belaboring this, I just want to make sure that you take a look at the research needs that Russ presented and make sure that if there's something there that you want to put in one of your two priorities, you tell us now. I think there's several, you know, hits here, duplications, if you will, from one list to the other, but there are some things here that doesn't

appear on both.

DR. ZIEMER: Jim, did you -- did you cross-calibrate those and see what --

DR. MELIUS: No, these were independently developed.

DR. ZIEMER: All right. I'm looking for the -- are there some that jump out from his list that --

MR. ELLIOTT: Well, the risk of transfer from the Japanese cohort, I don't think was on Dr. Melius' list.

DR. ROESSLER: That's -- that's the one the public brings up all the time. I think it needs to come up before this Board in a public forum to address it, although we might have to wait for BEIR VII for it.

DR. MELIUS: That was, I think sort of generally, this whole issue of applying the Japanese, how it's applied, so the dose -- dose issue, a whole number of issues have come up there and they're included in the sort of subtopics. And again, I think BEIR VII may preclude us from doing much now. The last item on Russ's list, Interaction with other workplace exposures, to some extent is outside our purview now, though I think it will come

up sort of dealing with the occupational workplace situation because as we get it presented by NIOSH, their studies have to address that issue also.

MR. ELLIOTT: So is it fair to say that you would put that in -- into the second level priority? And what about the skin cancer bullet, or do you see that? Second level?

DR. ZIEMER: Can we -- can we agree that we would include Russ's topics into our list?

MS. MUNN: Yes. Uh-huh (affirmative).

DR. MELIUS: Yeah.

MR. ELLIOTT: And I don't know if Russ had a comment, or --

DR. ZIEMER: By not naming them here doesn't mean there's no interest.

Okay. Russ.

MR. HENSHAW: Yes, thank you. I just want to mention that regarding the item on my list, I think it's on your list too, on DDREF we have authorized David Coker, who is under contract with SENES to continue working on that issue, and they are in fact working towards submitting that for publication, and seeking peer review, and we've asked and funded SENES to respond to whatever criticisms arise from the peer review process.

DR. ZIEMER: Thank you. And I think we should make it clear that even if something may not have risen to the top of our list right now, that doesn't preclude the staff bringing it forward as -- as information becomes available.

MR. HENSHAW: Dr. Ziemer, let me just clarify. Primarily focusing on the radiation effectiveness factor is the paper that Dr. Coker presented to the Board.

DR. ZIEMER: Right.

MR. ELLIOTT: I appreciate this. This helps me understand what your interests are so that I can marshall the resources to put it together for you, so we will balance that all out.

DR. ZIEMER: Thank you. Before the lunch break I just want to let the Board members know, and the members of the public as well, that I've been given a list of recommended dining. I think these are -- these are all restaurants in the near vicinity. I'm not sure who is recommending them. I don't know if this is Robert Presley's recommendation, or if this is the local -- local Chamber of Commerce, or these are the local restaurants who anteed up to get on a list or what, but anyway there is a list of restaurants, but it

doesn't tell where they're at.

The lunch break goes till 1:30, so we'll see you all back here then.

(Whereupon, a luncheon recess was taken.)

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BY DR. ZIEMER: (Resuming)

Well, we'll come back into session even though not everyone is here yet, but we want to move along.

We're pleased to have Dr. Sergio Bustos here this afternoon. He is Professor Emeritus at the Medical College of Georgia in Augusta. Dr. Bustos came to the U. S. originally as a Fulbright Fellow, and he's a graduate of the University of Chile in Santiago, and also was a graduate at one of the programs at the University of Rochester as well. Dr. Bustos is former Professor of Physiology at the University of Concepcion in Chile; he was also a Professor of Bio-Chemistry at the Medical College of Georgia. He has served as a consultant to the World Health Organization, and he's recently, since '95 really, been Chairman of the Savannah River Site Health Effects Subcommittee. And we're pleased to have Dr. Bustos here this afternoon to tell us about the Savannah River Site Health Effects Program.

DR. BUSTOS: Thank you very much. Can you hear me?

DR. ZIEMER: There's a little on/off switch on that. Make sure that that's.

DR. BUSTOS: I think now it's on.

Thank you very much for the invitation to attend this meeting on the Advisory Board on Radiation and Worker Health, and to tell you something about what we do at the Savannah River Site Health Effects Subcommittee. Through your web site I already got acquainted with your mission and your activities.

I became interested in the effects of radiation working precisely with radiation. I spent a large fraction of my academic life working with Potassium, Beryllium, Calcium, Iodine 131, S35, C14, Tritium, etcetera, so I think I qualify as a worker; so this is what qualifies me to appear before you here.

In addition, my specific area of research and teaching was nucleic acids and proteins, which are the prime targets for radiation. In 1995, the Savannah River Site Health Effects Subcommittee was established for the purpose stated here: To identify the needs of exposed and potentially

exposed populations around the Savannah River Site. And one of the functions is to make recommendation to CDC, and acts in an advisory capacity to NCEH, NIOSH, and ATSDR, and also evaluates the research and public health activities at the sites.

The SRSHES Membership, it's a very heterogeneous group; it consists of engineers, scientists, physicians, workers, nurses, housewives, it covers the whole spectrum. And these are, of course, individuals that are selected by the federal agencies, and what they bring is their experience or their -- and their scientific knowledge. And in a way it reflects the demographics of the area.

The -- the mission of the Savannah River Site was to study the potential health effects that, of course, are due to the releases of radioactive and hazardous material, radionuclides or chemicals from the Savannah River Site, and their site election would be the offsite population and the SRS workers. The -- we've had since 1995 -- I just can't believe that I have been the Chairman since 1995. The other day I went to CDC and I introduced myself to people saying I'm the Chairman for life of the SRSHES. But I think of this as this may be one of my last appearances.

Among the activities that we have undertaken are presentations; summaries; proposals; projects by the agencies; have recommended changes in the peer review protocols used by agencies; advised the -- the firm, the organization that conducted the dose reconstruction on the Savannah River Site, that's the RAC on Phase I procedures of the dose reconstruction procedures. We developed a brochure where the mission of the committee was spelled out; the functions, the compositions, the aims. At one point we instituted a toll-free line to -- for the people outside to have access to us and tell us what their concerns were; provided input to the Advisory Committee for Energy-related Epidemiological Research, ACERER. As a matter of fact, two of our committee members attended the meetings of ACERER; participated in Phase I and II of the Reconstruction Project, and by this, I mean participation, actual participation. We reviewed, or we went to the place, to the vaults of where the archives, where all the boxes, I think there were 50,000 in all, that were kept in the vaults of the Savannah River Site, and we were given special clearance, so we walked and opened, and saw many of the contents of them, and this was a daunting task for the

organization that was conducting the Dose Reconstruction Project. And so a modus operandi had to be established, and we participated in advising the -- the experts that were conducting the Dose Reconstruction Project on how to go about it. And I think that that simplified their task.

We are now in the process of analyzing, or rather, participating in developing the scenarios for radionuclide screening analysis. Following the Phase I, which was the search for the historical records of the Savannah River Site that I just explained to you, we also participated in the -- in Phase II, which was the definition of the source term and the pathways for contamination, the atmospheric and the water pathways, the kinds of radionuclides that escaped from SRS. And that resulted in -- in a book that was very, very heavy, about this (indicating) size, and this (indicating) thickness. I cannot remember exactly how many pages it had, but it must have had close to 800 or so pages, with many chapters which the experts had spelled in detail the equations and graphs, and their recommendations. And we divided the committee, this committee was divided into people who would review chapter by chapter, so we undertook

the task of correcting it, correcting the graphs; establishing whether there was clarity in the graphs; correcting the footnotes; the syntax, the explanations of this, rather, topic. And that was something that took about a month where we met at different places in Georgia and South Carolina. And following that, we are, at the present time, assisting in developing the scenarios for radionuclide screening.

Now, in one of our meetings we devised a strategic plan for Phase II that has to do with the epidemiological considerations. And the radionuclide screening was going to be done by staff at the CDC, and the chemical screening was going to be done by a contractor; but because of changes in priorities, the screening of radionuclides would also be done by a contractor. That has to do with the change in the focusing of CDC into bio-terrorism.

What is the, our committee's role in this? It's participate in the developing of exposure scenarios; participate in the development of risk-based ranking criteria; and participate in decisions on what future work lies ahead or is needed. And the first thing that we embarked on is the refining

and the fine tuning of the generic families that would constitute the population that lived around the Savannah River Site. And for this purpose there are six families, six categories that have been proposed. The first one is a rural family that lived just downwind from the site boundary; the second one would be an urban or suburban family just downwind of the site boundary; the third category is a migrant worker family living mostly outdoors; the fourth category would be a family that lives in a -- in a boat in the Savannah River Site. I have to remind you that the Savannah River Site occupies 310 square miles in the boundary between Georgia and South Carolina, and so the Savannah River Site flows at the boundary. And as a matter of fact, the -- the -- the small creeks and little rivers inside the Savannah River Site drain onto the Savannah River, so it's very proper that we do -- that we suggest this family living on a boat on the river; then a person living nearby that, in addition to that, makes deliveries to the river -- to the Savannah River Site, or people who catch beavers; and finally, an outdoors person who is fund of hunting and fishing, camping, etcetera. So for each of these family we are developing what are the

conditions that we're going to impose on it.

I am going to give you one of the examples that we have come up with. For the rural family scenario, that, we would have to choose the location, that's the closest downwind location where there could have been farms in 1955. The -- the number of adults, infant born in 1955, an infant born in 1964. Why 1964? Because that's the year of the highest release of radioiodine. We have to use the consumption values to make us take into consideration the -- the time that is spent outdoors and working in the soil, whether the family drank fresh milk from a backyard cow, and whether their crops were irrigated from the Savannah River Site. So for each of the other categories that I described for you, we are going to establish what the main criteria, the main characterizations.

And finally, we also have the -- the public involvement that participates by attending our meetings, sharing ideas with the members of the committee, sending concerns and questions, signing onto SRSHES mailing list.

And one thing that I neglected to tell you is the way that we conduct our meetings. And we started first following the -- the Roberts Rules of

Procedure, but they were disposed of, in a manner of saying, by the Bustos Rules of Procedure, which are very similar to the ones that you use here, and that's that we allow people to express their opinions ad nauseam. I guess I exaggerate. I guess I took the liberty of exaggerating it a little, but it's -- but what we do is very similar to what you do. So, any questions?

DR. ANDRADE: Dr. Bustos, after hearing about your background both in the academic arena and in working on this Subcommittee, I imagine that you've had a chance to -- am I speaking loud enough -- okay -- I imagine you've had a chance to ponder the whole question of the combination of potential effects from radiation and hazardous materials. Have you formed any opinion, come to any conclusions, have anything that might provide a vector for this -- for this Advisory Board on whether there is fruit somewhere in scientific studies on the combined effects? Is it -- is it possible to distinguish between the effects, or have you seen, for example, they may be additive, they may be multiplicative, that sort of, or would we just be barking down -- just going down a path that will never bear fruit if we start to look at that

arena?

DR. BUSTOS: Well, I can tell you that my opinion, when I said that I was a worker, when I was working with radiation, that has to be very, very well qualified because I was -- I was working, but I was following very specific and carefully prepared protocols and had all the shields and all the protection that was needed. But I can tell you that when I -- when I started I was counting gamma radiation in a counter on Sunday evenings, Sunday afternoons without any protection whatsoever, none. I had a mixture of beryllium, calcium and potassium, and we were separating these isotopes after they had passed through the heart to the myocardium of a dog, so I have the -- I have that excuse, so I became very sensitized to that aspect. Of course, you know, in -- in the workers realm I do not believe, I don't have first experience, but I think that those protocols that we used in the lab are not followed exactly in the same way. So there is, I think, ample ground, you know, to investigate whether the effects are multiplicative, cumulative, etcetera, etcetera; you will not -- you will not be barking in the wind.

DR. ZIEMER: You mentioned the membership of

your group including engineers, scientists, physicians, general public. What's the total size, numerically, of your Committee and Subcommittee? How many people?

DR. BUSTOS: How many? We have -- it differs depending on the -- on the time, but we currently have 18 members.

DR. ZIEMER: That's the full Committee?

DR. BUSTOS: That's the full Committee, but the Memorandum of Understanding allows us to have 30 members, but because of medical considerations, among them, many-headed monsters would not work well, so it was -- it was agreed that a Committee of 18 would be the most suitable. Of course, all of this is based on empirical experience.

DR. ZIEMER: And Dr. Roessler has a question.

DR. ROESSLER: You mentioned earlier in your talk that the Committee is interested in potential health effects and on one of your slides you have the offsite population, and you also have the workers. From what you've said though, I -- I assume that the dose reconstruction was primarily on the off-site populations.

DR. BUSTOS: Yes.

DR. ROESSLER: But have you done any work then on the dose reconstruction for workers?

DR. BUSTOS: No, we have not.

DR. ROESSLER: Okay.

DR. BUSTOS: But it is a concern of the Committee and theoretically, if the issue is brought before us and we have people who have worked at the Savannah River Site who appear before our Committee relating their experience, and the ailments that they have been affected with, naturally the -- the doses that were established for the offsite population will also apply in-site too.

MR. DeHART: Roy DeHart. Is there anyone that's going to go over a little about the Savannah River Site in terms of its operation to the degree that it can be discussed around the table?

DR. ZIEMER: Physical description of the site and the activities there?

MR. DeHART: Yes. He mentioned the size, which is quite considerable. We have two --

DR. ZIEMER: I noticed there was --

MR. DeHART: We have two overheads.

DR. ZIEMER: -- was handouts. I'm not sure of the source of those. Are these --

DR. BUSTOS: Yeah, I --

DR. ZIEMER: Can you talk a little more about the --

DR. BUSTOS: -- I have provided two of these. If we can put the -- if we can set up the overhead projector.

Yeah, the -- the heart -- the heart of the Savannah River Site is constituted by the -- by the five reactors and the chemical separations. And adjacent to it there was an area where the fuel targets were prepared. And adjacent to the area there was also heavy water -- heavy water plant. This heavy water plant had the function of using the Savannah River -- Savannah River water and converting it to heavy water. That heavy water was needed as a coolant in the reactors. Now, the heart of the Savannah River Site is the five reactors, R,P,L,C,K. And the Canyons, the H-Canyon, and the F-Canyon that are the chemical -- where the chemical separation is produced, and here (indicating) is the heavy water plant that provides the coolant for the -- for the reactors. By the way, all the -- all the reactors are deactivated now, so -- and then the chemical separation that takes place in the Canyons, in the absence of a presence of humans, by the way, there is waste, there is chemical waste and there is

radioactive waste that is generated. And this is then taken -- or was taken to tank farms or to other areas that are called seepage basins and the Z-area with saltstone. So this is where the area, the M-area where the reactor components, fuel and target, were assembled, then they were taken to the reactors. And the function of the reactors, during the Cold War, and post-Cold War, was to produce plutonium and tritium. That was the main. So that's in a nutshell, that's a -- that's a lot, you know, there would be a whole lecture to give on the subject, but that would be SRS in a nutshell.

One of the activities of the Committee that I neglected to -- was to tell you that when the face tube, the analysis of the source term and the emission of radionuclides was taking place, then the Committee helped determining what area would be the area that was going to be used for the sampling, for the analysis. And that was an area larger than this (indicating) one because this is the -- this is simply the -- the area of the plant with the five reactors, the C,K,L,P,R and the Canyons, the F-Canyon and the H-area that where the chemical separation was. And they are all strategically positioned within this (indicating) circle; whereas

the -- the M- and A-areas, that was the fuel and target fabrication areas, and the heavy water areas were way apart. This (indicating) is 310 miles; this (indicating) is the Savannah River Site; and these are the streams that flow from the interior of the Savannah River Site to the Savannah River.

Again, this is a very, very brief summary of what could be said on it.

DR. ZIEMER: Thank you. Other questions?

MR. GIBSON: Doctor, you mentioned that you guys went through the historical records in the vaults and you looked back at how they performed their analysis on some of their monitoring they had done and stuff. How valuable do you think that was to your research on --

DR. BUSTOS: Excuse me. I lost track on that.

MR. GIBSON: Okay.

DR. BUSTOS: Would you start again?

MR. GIBSON: You mentioned that you had looked through vaults and historical --

DR. BUSTOS: Vaults, yes.

MR. GIBSON: -- records --

DR. BUSTOS: Yes.

MR. GIBSON: -- and looked at how they had

done their analysis and --

DR. BUSTOS: Exactly.

MR. GIBSON: -- kind of recreated them.

DR. BUSTOS: Yes.

MR. GIBSON: How much value do you put on that in ascertaining a dose that a population might have got?

DR. BUSTOS: Oh, that was invaluable. It was inventory, you know, when hydrochloric acid came, nitric acid came, all the chemicals that came to the plant. And then everything that was -- that -- that was annotated was contained in there, so it was a very -- that was a sine qua non starting point.

MR. GIBSON: So did you find any anomalies when you recreated these -- these analysis and had other people look at them, or?

MR. BUSTOS: No -- no anomalies were found, except that it was -- at one point there was a closely kept inventory, and at other times there was not as well kept as would have been desirable. But that was -- that was corrected by interviewing the people who were in charge of that, and were retired people who were still around who volunteered to provide information on precisely the missing parts.

MR. GIBSON: Thank you.

DR. BUSTOS: So -- so there was oral and written history.

DR. ZIEMER: Has the research agenda of the groups that you advise changed as a result of your reviews? I noticed that you evaluate the adequacy of their research activities. Has what you've done caused them to change direction, change priorities, change research designs?

DR. BUSTOS: Well, throughout the dose reconstruction period, that took several years, the scientists who were conducting this, chemists, biochemists, nuclear scientists, etcetera, appeared before the Committee and provided us with a step-by-step detail of what they were doing. And they were subjected to a question period, very, very intense, that ranged from the scientific part to sometimes the social aspects, the community aspects. So the Committee was involved not only in being apprised of the -- the rate of the project, but as of the particulars, and they were asked in detail to specify what -- what it meant, not -- you know, because of the heterogeneity of the -- of the Committee, some of the members did not have the -- the knowledge, but they had common sense and they

asked to be explained in terms that were very clear, understandable, the meaning of what being said, whether it was Owen Hoffman from SENES to John Teal, everyone was required to explain in detail and very clearly what had transpired. And because of that, you know, at the end of the Dose Reconstruction Project, then there was a summary, an account, of what had been done that had to be understandable for people who have very little knowledge, which was a very difficult thing to do, by the way.

MR. ELLIOTT: I think one of the accomplishments that you point to here in response to Dr. Ziemer's question, the change in peer review process that your Committee effected across the three agencies, ATSDR, NCEH, and NIOSH, in my opinion that was quite an accomplishment and it effected some changes in how we, in the agencies worked, and how we got peer review on our individual research projects. Would you -- would you agree that that -- I mean you highlighted it earlier, but I think it's something that answers Dr. Ziemer's question in a way.

DR. BUSTOS: Yes, exactly.

MR. ELLIOTT: Just so the Board understands, there are four subcommittees, and as the Board goes

around having your meetings at different sites we would intend to invite the other Chairs of the other three. There's a subcommittee in Oak Ridge that was just recently established within the last couple of years, they don't have the tenure that Dr. Bustos has. There's another -- that subcommittee is sponsored and administered by the ATSDR, Agency for Toxic Substances and Disease Registry. Dr. Bustos' committee is sponsored and administered by the National Center for Environmental Health. The committee -- subcommittee at Hanford is sponsored also by the ATSDR, and it's been in existence the same time frame that yours started, I believe, Dr. Bustos. Then the fourth committee is out of the Idaho National Engineering Lab, and they were also in existence from the very start when Dr. Bustos' committee came on line, and it is also sponsored by NCEH.

DR. BUSTOS: Any other questions or comments?

DR. ZIEMER: Thank you, very much. That's been very informative for us and we appreciate your being with us today.

DR. BUSTOS: You are very welcome.

DR. ZIEMER: Our next Agenda item is one

that, in a sense, carries forward from the past, and that is the area of the Board's review of dose reconstructions. I want to refer you, first of all, to the material under the tab called Discussion Documents, which includes the current version -- or versions of the various parts of the Request for Contract that has been developed through our workgroup. And then there's a summary of the slides that were used this past -- was it in July --

DR. ROESSLER: Uh-huh (affirmative).

DR. ZIEMER: -- past July. And to begin our -- well, let me make a few remarks, sort of preliminary remarks, and then Larry, we'll let you make some remarks and I want to call on Mark Griffon as well. But you -- you recognize that we -- at our last meeting we had the closed session dealing with issues around the Request for Contract. I'm going to ask Larry to give us an update on that process. We also need to get some thought about how we need to position ourselves as a Board, so that we're ready to go at the point at which the Contract is ready to go; what will our review process be; how will we be structured as a Board to carry out and conduct the reviews themselves with the assistance of the contractor that is chosen.

But, Larry, why don't you give us a quick update first on the -- the procurement process.

MR. ELLIOTT: Sure. First of all, let me say that the document you have in your briefing booklet under the tab that Dr. Ziemer pointed out to you that says Draft 01/ -- whatever the date is on there -- that is the document that we understood you all to have reached consensus on and passed at your last meeting in Cincinnati in January.

It is certainly -- you still have an opportunity, this document has not gone forward into the procurement process as of today. We need to have from you some -- some clear direction at this point on how you would want to proceed, and I will get into that in a moment, but I'd like to say at this point you still have an opportunity to make or effect any further changes before this procurement is initiated. This is your last opportunity to do so. We -- and again, we have not put it into the procurement process for this reason: We -- we left the January meeting and having heard a few of the Board members -- I didn't hear a consensus in this regard, but I -- and I heard people speak to the other side of this issue as well -- but that NIOSH was in a situation here where there could be a

perceived conflict of interest with your audit of our work being procured for technical consultation to assist you in that being procured through NIOSH. So I took that discussion to heart, I heard, you know, I heard what certain Board members had to say and what members of the public had to say in that regard, and I went back to my principals and talked about it and offered a suggestion to them that could we not find a way to put some distance between NIOSH and the effecting the award of this procurement, and the administration of this procurement. I proposed to -- to Dr. Howard that -- who is the Director of NIOSH -- that perhaps, you know, we could seek another agency to -- to handle this procurement for the Board. I then approached and had some discussions with Mr. Pete Turcic, and I think he's in the audience. Pete's back there. He -- he's my counterpart at the Department of Labor. He's the Director of the -- of their Compensation Program on this -- on this Act, and talked to Pete about whether or not it made any sense for, in his mind, for DOL to effect this procurement and make the award, or whether there was another option. And we -- we talked about that at length. We have pursued other agencies as an option; we talked about the

General Services Administration. So what we boiled down to is a decision for you all to make, and that is whether you would prefer that the Department of Labor effect the award of this Contract and administer the Contract, or you'd just as soon see NIOSH retain it and make the award, and monitor the progress and make sure that, you know, we were working in your best interests.

We've -- you know, in our deliberations we identified that the other agency options were not a viable option in that we could not make sure that they would give due diligence in the processing of this particular procurement, so that's where it stands. It is not -- we've wrapped it all up, it is in the form of a -- what we call an RFP, Request for Proposals. I need to hear from you all what your consensus is with regard to whether NIOSH should effect this RFP and administer the award, or whether you think that the Department of Labor makes more sense to do so. So I would welcome your -- your discussion in that regard, and your direction.

DR. ZIEMER: I wonder if it would be of any value to the Board to also hear from Pete on this issue from Labor's perspective. Maybe Pete will tell us why it should go to NIOSH and NIOSH will

tell us why it should go to Labor.

Pete, if you're willing to come and address the Board a little bit about how this would look from your perspective and anything you think we should know in terms --

MR. TURCIC: Okay.

DR. ZIEMER: -- of that issue.

MR. TURCIC: Sure. In my discussions with Larry, the way we would envision that if DOL were to, you know, handle the procurement and then the ongoing coordination of the task orders, we would basically do it in a manner where we were the administrative arm of the Board for managing that contract. We would have -- we envisioned that we would have our office of the Assistant Secretary for Administration and Management handle the procurement in, you know, with naturally, you know, having individuals on the procurement, on the evaluation board, on the evaluation team, and then just administratively carrying out that procurement. And then following that, we would envision a system where within the Department of Labor we would have a liaison to coordinate -- any of the task orders coordinate with the Board, so it wouldn't be that we -- I guess the technical term would be the

contracting officer's technical representative, but it really wouldn't be -- it would be more of a administrative representative where the task orders would come from the Board, then those task orders would then be implemented and put into the system and tracked, and from an administrative standpoint DOL would merely be fulfilling a function of being the administrative arm for providing that kind of contractual services, you know, to the Board for that process. From DOL's perspective, the -- it's very important that the work of the Board in this overview and function is very important to us in maintaining the integrity of -- you know, we have to adjudicate if -- if there are issues that come up, that people raise issues concerning the dose reconstruction process where that is adjudicated is after the claimant gets a recommended decision; so the, you know, from that perspective the quality control function that the Board will be, you know, carrying out in this process is extremely important to DOL, and we would do whatever, you know, whatever makes sense for administratively carrying this function out.

DR. ZIEMER: Larry, do you have some additional comments?

MR. ELLIOTT: Well, suffice it to say that if -- if it was NIOSH carrying forward this procurement and processing the procurement we would do everything in due diligence and with the same amount of interest and effort that Pete has just described to you as well, so. We talked about having a, you know, a technical liaison from NIOSH work with whoever their technical project monitor would be for the contracting officer. The Board would create its task orders, and whether it was run through the NIOSH procurement system or the Labor procurement system, I don't think there's any difference in the process, the sequence of events, or the amount of effort that would be accorded to this -- this whole procurement.

MR. TURCIC: Hey, Larry, in some of the earlier discussions, one other piece of it, there was a question came up about, you know, how DOL would interact with the Board and with NIOSH, and one way to address that would be a Memorandum of Understanding specifically for, you know, for this project.

DR. ZIEMER: Provided such Memorandum could be developed at a more rapid fashion than others.

MR. ELLIOTT: I think we could do that.

DR. ZIEMER: Now, could either of you, or others help me get a feel for the extent to which conflict of interest could still be perceived? This is also a Department of Labor program insofar as they do make the final decision on adjudication of the claims, so I'm trying to get a feel for what we gain. It seems like you can gain certain things in one direction and lose others, so can anybody speak to that?

MR. ELLIOTT: Well, I'll attempt, and certainly let Pete speak his mind on this too. I think if the approach was to use the Department of Labor's process, then the gain would be to NIOSH; we would find ourselves somewhat distanced from -- from this whole process. Certainly the perception of conflict of interest exists for both agencies because of our involvement in this program. And that burden will just be shifted from NIOSH's -- from our agency to theirs. And Shelby Hallmark, Pete's boss, knows this and we've talked about this, so I don't know that it gains much, if at all, whoever has this, either DOL or NIOSH, we will be walking a tightrope and we will be doing the best that we can to manage and control perceptions of conflict and avoid any actual conflicts.

MR. TURCIC: I agree with the points Larry made. One aspect of it would -- from DOL's standpoint would be that -- in the way the process works is that if an individual, they have, you know, once -- once a recommended decision is made, then the claimant can raise issues during the final decision point, and then from there they can appeal that to the District Court. So, from, you know, from that standpoint it would just be which part of the, you know, process and where the individual claimant would have recourse.

DR. ZIEMER: Let's ask others. Jim has a comment.

DR. MELIUS: Yeah. First of all, I'd like to thank Larry and Pete for, no matter what we decide or recommend here today, for making the effort to sort of develop an alternative because I think it's good for the credibility of the process that we did consider an alternative to NIOSH doing this procurement should NIOSH go ahead and the, you know, reasonable alternative was, you know, a practicable one was looked into. I personally have trouble weighing the benefits versus the possible risks of problems with moving it to DOL without sort of thinking through the whole process, and I think

there are different points at which conflict can arise or perceptions of conflict. There's also different points at which, you know, scenarios where certain problems may arise and, you know, which agency is better or worse. And some of these -- as with the conflict of interest, some of these scenarios are unlikely to occur, but what if things aren't going -- going well and at least to me, in order to evaluate this, I'd like to sort of know more details about the -- how the process should be working, or how we plan the process to work for actually get out these task orders and conducting this review. And then think -- then almost work back, which then, you know, how much do we gain from the Department of -- of moving this to the Department of Labor and how much would we lose from the Department of Labor, you know, at least potentially. And it's all going to be, I guess -- I think, you know, realistically either agency could do it fine. I mean that's -- and it's not a clear-cut gain in perception either from either agency as both Larry and -- and Pete have pointed out, but -- but I think the details are what are going to be to some extent important and the procedures we set in place. As I said, I'd almost rather work from --

let's work through the procedures; how are we going to the procurement and so forth; then go back and say can both agencies deal with this. And then -- then questions about which would be better, what would be the delays involved in doing an MOU. We don't have a great example up there historically to work off of right now. And I want to go back through my transcripts and count the number of times Larry has said soon, or the next meeting. But -- but I mean I -- we do have to look at that realistically, but it is the procedures that maybe work -- I would prefer that we work on them and then go back to this issue.

DR. ZIEMER: A good point, Jim. And there's no reason we have to, for example, decide at the front end, but we have to at least know that's a decision that's part of the overall picture as we proceed here today and tomorrow.

Roy, a comment.

MR. DeHART: Thank you. Clearly, NIOSH has played a role in helping us prepare this document as a procurement document to meet the Federal Regulations, etcetera. I would ask the Department of Labor who has reviewed or who all have reviewed this document, so that they're comfortable with it

as -- as it currently is developed?

MR. TURCIC: The Division of Energy and Employees Compensation, we've been -- we've reviewed it and looked at it. And, you know, Jim made a good point about the, you know, the process -- you know, we have ideas of how, if it was administered by Labor, how we would do that, and maybe what we need to do is add some, you know, details to that.

DR. ZIEMER: But I think your question is: Is this in a form that looks like they could handle it readily without major --

MR. DeHART: And are the procedures in place to do that, and I think we're being told that there are planned procedures.

MR. TURCIC: Yeah, the procurement procedures are all in place in order to do that. Either NIOSH or DOL could pick up what has been done and affect a procurement, you know, that's -- those are government regulations imposed to, you know, HHS or DOL, so yeah, those are in place and can be done readily.

DR. ZIEMER: Jim.

DR. MELIUS: Just to clarify or reiterate on Roy's comment. I think what's important, this review is the Board's -- it's our function, we're

mandated to do this under The Act, and so the process should serve our functions, what we need to carry -- carry this out, and I think by -- we start with what do we need to feel comfortable and have a robust and solid scientifically based review process. Then the questions will come up, you know, I mean clearly just as Roy's question if DOL said no, we'd have to start all over. Well, there's a time issue or something. So I think it's appropriate as we go along to ask whether or not there would be a problem shifting to DOL. There's a number of issues we really haven't, at least the working group may have talked about with Larry and his staff, but the whole Board hasn't, and I have questions about a number of issues and procedures that -- that I think are critical in terms of the Board's carrying out its mandate that we need to work through also.

DR. ZIEMER: Other comments, on this point at least, on the issue of procurement?

(No response.)

DR. ZIEMER: Okay. If not, can we agree that we'll proceed with the related issues and then we'll have to return to this at some appropriate point.

I want to give Mark an opportunity, if you have any comments to add on the procurement documents, the final versions, anything you need to point out to us or highlight, Mark?

MR. GRIFFON: I don't -- I don't -- I guess on the procurement documents, I don't think I have anything to add at this point. I think the second set of overheads are -- after those three documents is a set of overheads from one of the earlier workgroup presentations, and that sort of goes through some of the other issues regarding procedure I think came up in our discussions, such as selection and sort of a process of how the Board is going to be now faced with a contractor and with NIOSH, so I don't know if people have had a chance to look at that, but they may be more relevant to the discussion that we went through.

DR. ZIEMER: Then, what we're faced with then is the issue of, in a sense, mapping out the process for how the Board will review dose reconstructions; how the work will flow; do we need a subcommittee, a permanent subcommittee that will, for example, decide on the cases that -- that will be reviewed; what -- what will the product of those reviews be, those kinds of questions, so there's a

whole series of things beyond the procurement that we need to consider. The ideal thing would be that once the procurement is issued and a contractor is selected, that we're ready to go knowing what we will do, how we're structured to do it, and then we simply move from there. And it may be that we won't be able to close all the issues today and tomorrow, but at least we want to identify what they are.

I -- I guess I'd be willing to have people raise the issues now. I see Jim's already raring to go, and Wanda is getting ready to go. Jim, go ahead.

DR. MELIUS: No, no, actually no. Wanda had hers up.

DR. ZIEMER: Wanda, do you want to go? Okay.

MS. MUNN: I just had a question based on your comments. Has -- have we then decided that we are going to use a subcommittee rather than a working group to do this? Has that decision been made?

DR. ZIEMER: Let me answer it in the following way. The difference in definition between a Working Group and a Subcommittee has to do with tasks and longevity. The Subcommittee has an

ongoing task and has a different set of rules by -- by which it operates, as compared to a Working Group, which is pretty much Ad Hoc; it has a given task, it's a pretty much short term, and it's over with. So one of the decisions -- or one of the issues the Board will have to decide is do we wish to have a Subcommittee to kind of oversee this task of dose reconstruction reviews because it's clearly an ongoing task and -- and we would be subject to -- in fact, I think we have in the -- the -- we have the Federal definitions of a --

MS. MUNN: Yes, we do.

DR. ZIEMER: -- Subcommittee and the *Federal Register* requirements for that are in the packet here to recognize the implications of that, and --

MS. MUNN: That was my concern.

DR. ZIEMER: -- we need to be careful that we don't try to avoid that by saying well, we're just going to have a --

MS. MUNN: No.

DR. ZIEMER: -- series of Ad Hoc Committees, that's not going to --

MS. MUNN: No, that won't do.

DR. ZIEMER: -- do it.

MS. MUNN: No.

DR. ZIEMER: So it appears to me, at the moment, that this is an ongoing task and either the Board does it as a Committee as a whole, or we say that we need a Subcommittee, or perhaps more than one. But -- but we have not made a final decision on that, but I think it appears right now that there may be -- need to be some subset of this Board that has that as a responsibility.

Does anyone want to speak to the issue of requirements?

MR. ELLIOTT: I just wonder if it wouldn't be beneficial if Cori spoke to the differences between a Working Group and a Subcommittee. The Subcommittee -- and she can explain this better than I -- but, you know, a Subcommittee operates as, in a public way; a Working Group doesn't have to. If you have a Working Group, it has a life to itself that once its mission is done, like this Working Group is charged to find the options available to you to do your review, and you're done. So now -- and that's a finite, discrete task. A Subcommittee has a more long-term involved Charter of Mission that's it been given, so.

MS. HOMER: A Subcommittee must be federally established, or formally established as well, which

I think there's some examples of how that might be done. I believe the Board probably has a different idea in mind of what their Subcommittees would be formed as, or like, and because your tasks are different, then a conventional Subcommittee would be. But the general rules apply: the openness, announcement in *Federal Registers*; availability to public and anybody who wants to attend, either via conference call, or in an open meeting. All of the rules that apply to a full Board meeting apply to Subcommittee meetings. Again, as Workgroups go, very, very finite specific tasks, and then the Workgroup is done, so.

DR. ZIEMER: Thank you, Cori. Now, keep in mind that the Subcommittee is not necessarily doing the reviews of individual dose reconstructions, they are probably overseeing the flow of work, deciding what percent or what numbers of different categories of dose reconstructions will be reviewed, perhaps assigning the tasks of the review process to Board members and consultants, that kind of thing. As I would see it, they're not actually the group that's necessarily sitting there reviewing particular projects, or dose reconstruction. Is that how you saw it, Mark?

MR. GRIFFON: Yeah, that's similar to the way we outlined it in some of our, you know, in some of our earlier discussions, I mean we talked about having a Subcommittee to do selection, and selection of not only of individual dose reconstructions, but site profiles to review, and things like that. And then to have sort of rotating Board members working with the contractor or contractors that are doing dose reconstruction, so that we would sort of split the share of the work on the actual reviews, so that's certainly the way we constructed it, yeah.

MR. ELLIOTT: If I could add to that, kind of the way I had envisioned what you've been talking about in the Working Group --

WRITER/EDITOR: You're mike's not working. I'm sorry.

MR. ELLIOTT: Now I'm on?

WRITER/EDITOR: Yes.

MR. ELLIOTT: Okay. It's magic. You could have a panel of Board members working with your contractor as Working Groups, you know, the finite task there is work with the contractor, come up with a review of a sample of dose reconstructions that you have been given as a panel. The Subcommittee itself could identify what dose reconstructions of a

representative sample would be reviewed, and how those are brought to the Board; so you could reconvene your panels as you need them -- or Working Groups as you need them. That's one scenario as how it might work.

DR. ZIEMER: Any other general comments? Jim, did you have one?

DR. MELIUS: I don't know quite where we're going, if we're going to discuss this Subcommittee/Workgroup issue more, or do we need to defer that for a while, or?

DR. ZIEMER: I think, again, we're trying to get the issues on the floor --

DR. MELIUS: Yeah.

DR. ZIEMER: -- because none of them are sort of made in isolation, and it may be helpful to identify what -- what particular things have to be done, and then try to put them together.

Do you have another comment?

MR. ESPINOSA: We're a small group -- we're a small group as it is. Does a Subcommittee have to be a majority of the members?

DR. ZIEMER: No.

MS. ESPINOSA: Okay.

DR. ZIEMER: No. I don't recall that there

are actually any size specificity to it.

MS. HOMER: There are no specific, no, you can have it as two people if necessary.

MR. ESPINOSA: I was looking through it and I couldn't find that there.

DR. MELIUS: And it can include outside members?

DR. ZIEMER: I believe you can have outside consultants.

MS. HOMER: Consultants, not members.

DR. MELIUS: Yeah, consultants, excuse me, not members.

DR. ZIEMER: Roy?

MR. DeHART: I'm not trying to avoid the formality of the Subcommittee, but I see it being stifling in terms of flexibility and ability to move quickly and be able to handle a lot of work. I would think that we could do that in Working Groups, still keeping the tasks very limited, very specific, and move from one Working Group to another Working Group, to another Working Group, different people, and avoid the formality of a Subcommittee, and that's what I'm going to be trying to think about as we're going through.

DR. ZIEMER: Yeah. You may be suggesting a

scenario where the Board acts as the Committee as a whole to determine the nature of the work. The part that you just described sounds like the second part of what Larry was talking about; these are the subsets which work on -- it's like a Working Group that has a task of reviewing this dose reconstruction and then they're done, as opposed to the coordinating function of deciding which sets of -- of dose reconstructions are to be reviewed and that sort of thing.

DR. MELIUS: Not disagreeing with that sentiment, trying to avoid, you know, additional or formal meetings and so forth, but I think one of the criteria we need to think about with that is, is the function so unwieldy or practical to do as a full Board meeting, or that the waiting for full Board meetings could delay that; but at the same time is a function that there should be some transparency to, that the public should have the opportunity to comment and be aware of what was happening with the Committee, there would be formal minutes and so forth of that. So there may be functions that are in between what a Workgroup should do -- could do and there are -- I guess the third levels that are sort of Workgroup reviewing it, you know, individual

case or something and going through all the documents is not something that can necessarily be done easily and in public, or should even be done in public. But I think we have to be a little bit careful about sort of setting up a series of Ad Hoc Workgroups that sort of hide this from the public as a way around that process. And that there could be something in between also that where a -- for example, a Subcommittee that would meet regularly by conference call once a month to do this function may be a way, you know, it could be announced in the *Federal Register*, people could participate maybe one way in between of dealing with certain -- certain selected issues, selecting the, you know, the nature of the cases to review, the process or whatever, to do that. At the same time it's a little harder to see where making assignments and so forth will be easily done that -- that way either, and where that would fit. But maybe if we work through what exactly we would -- what the steps would be, that -- that we could then decide. But I do think we have to keep in mind that it is a -- there should be some -- the more transparency there is to this process, the more credibility it will have.

MR. GRIFFON: Just one -- one more -- what

did he say, ad nauseam we comment. Anyway, just I mean one more question on the Subcommittee. As I understand the -- the -- looked into the FACA Rules a little bit, and it says that if there's no further deliberations on the Advisory Committee, then the Subcommittees have to adhere to the public -- public functions, that they have to be held publicly, but if they -- if you read that backwards, then if they, you know, the Subcommittee can act more like a Working Group where we select cases, select the -- make the criteria, select cases, and bring them to the full Board, and the Board deliberates over it and agrees and puts that forward, I don't think, in that case, it's really a Subcommittee that has to adhere to the public requirements.

DR. ZIEMER: Well, we need some expert opinion on that.

MS. HOMER: I would like to point out, which I probably didn't make clear before, whether or not it's a Workgroup or a Subcommittee, the decisions or work done by Subcommittees or Workgroup has to be brought to the full approval of the Board.

DR. ZIEMER: Well, yes, and the Workgroup in -- in fact, brings its findings to the Board and at which point they become public. It was just the

issue there that they can deliberate privately while developing the work product that they bring to the Board. In the case of the Subcommittee, that -- closed deliberations are also done in an open forum.

MR. GRIFFON: And the only reason I raised that is not that I don't want it to be open, but that the flexibility question that Roy raised, you know, might be easier to conduct without that.

DR. ZIEMER: Now, this again is not an issue we have to decide at the front end because it may be driven more by what the process itself looks like, how we're going to do the review. For example, we may need to begin looking at how it is we're going to conduct these reviews; what is it going to look like in terms of consultants and Board members; are we going to have a series of small panels or what. And maybe we need to think about working from that end and working back to see what the total picture would look like. Are we going to have a number of these subset groups working with the consultants, or -- or having consultants do the work and then meeting with them, or that kind of thing. We haven't really decided how that's going to happen, right? And then decide what that's going to mean in terms of participation by this Board for example, is

everybody on the Board going to be involved in that, or just certain ones. Again, that's -- the Board can decide to do this anyway it wishes, I think at this point. We're not bound by any particular requirement.

So I'm going to suggest, and this may be a good time to take a break because you may need to collect your thoughts on that, but to determine what the reviews are going to look like and what the product of those reviews will be, and then back that up. We have an idea, and I think we have an idea of the numbers of reviews, we've talked about percentages and so on.

Just before the break I want to remind members of the general public if you do wish to speak at the public comment period, please be sure to sign up.

We'll take a 15-minute recess.

(Whereupon, a recess was taken.)

BY DR. ZIEMER: (Resuming)

Now, before we go further in discussing some of the issues in the review process and so on, we have an opportunity to learn a little more about the Task Order Contract Award Processing and the length of times involved. And Martha will walk us through

that. There is a handout that should be at your place. It's a blue background that says Task Order Contract Award Processing.

Martha, are you set to go on this?

MS. DiMUZIO: Yes. Larry asked that I just provide you all with some information about how exactly the task order process will work, so obviously this is all after award of the contract. But just to give everyone a little bit of information about the timing on the contract, once we're ready -- once we're -- well, at least for the NIOSH process, obviously it needs to be determined whether NIOSH or DOL is going to handle the contract, but if it were to go through the NIOSH process we would need to send it -- we're ready to go basically now. The documents that -- it would need to go to Atlanta for approval, that usually takes again, about a week for processing, but for actual, formal solicitation and everything, it has to be out on the street for a minimum of 30 days and it can be as much as 45, but we would be requesting 30 days with proposers given a minimum of 30 days to respond. So then you would have the technical evaluation panel meet and evaluate those proposals and that's not really on this slide here

(indicating), I apologize. I thought I should -- this is sort of after award which is up on the screen, but I realize no one knew the timing for actually award of the contract, so after, you know, the technical evaluation panel meets and so forth, it could be, you know, a hundred and -- a minimum of 120 days from the time that NIOSH submits the contract to the Procurement Office before an actual award is made. So just some initial information about the actual award of the contract and the timing on that.

But what we have here is the contract has already been awarded and we're ready to start submitting task orders to the contract, so the Advisory Board meets either as a Working Group or a Subcommittee, develops the task order request, along with the Independent Government Estimate and submits it to NIOSH. So it will come to OCAS in Cincinnati, and we'll prepare the necessary funding information, and then that needs to be forwarded to Atlanta for approval by both the NIOSH/AD Office and the CDC Financial Management Office. And historically, that takes approximately two weeks. Then -- then Atlanta will forward the information on to the Procurement Office, who will prepare the task order and submit

it to the contractor proposal; again, about a week. The contractor will prepare the response to the Board's proposal, and according to the contract, they have up to 14 days to submit their proposal. That's then -- we receive the proposal back, that is then reviewed by the Advisory Board; if they accept it, it can be awarded; and I will say approximately another week. If the Board requests revisions to that proposal, the contractor has an additional week to respond to any revisions. So basically what will happen is, you know, on average, once the Board submits a task to NIOSH, it will take approximately seven to eight weeks for that task to be assigned to the contractor to start work.

DR. ZIEMER: Okay. Everybody understands this is after the procurement?

MS. DiMUZIO: This here is after the procurement.

DR. ZIEMER: This is two months, sort of minimum, if a procurement is completed and we have a contract.

MS. DiMUZIO: Right.

DR. ZIEMER: Now, remind us again how long under optimal conditions will the main procurement take? I don't know --

MS. DiMUZIO: Under optimal conditions --

DR. ZIEMER: Optimal conditions.

MS. DiMUZIO: Under optimal conditions the proposal would be out on the street in the *Commerce Business Daily* for 30 days --

DR. ZIEMER: Right.

MS. DiMUZIO: -- so the bidders would have 30 days to respond -- it would be out as an announcement for 30 days, and then during that time frame they have the -- the bidders will propose their thing; then the Technical Evaluation Panel is established, and they review the proposals that have been submitted. That -- depending on the quality of the proposals that are submitted, and if you need to go back and forth and do best and final and so forth, that could be an additional two to three months, depending on the number of bids and so forth. And then after the Advisory -- after the Technical Evaluation Panel has selected the -- the best proposal, from there it usually takes about another two to three weeks for the actual award.

DR. ZIEMER: So it would appear that somewhere in the range of three to four months are required to bring the procurement to closure, and a couple of more months to get the first task order in

place. So I'm just trying to make sure the Board has a feel for timing here, that you're ready to go on the first task order, if you started today with the procurement, that it would be somewhere approaching six months from now before you're ready to go with the first task order. Is that -- am I correct on that?

MS. DiMUZIO: Yes.

DR. ZIEMER: It might be slightly better than that?

MS. DiMUZIO: It could be slightly better, but --

DR. ZIEMER: But not -- not very much better, and it could be a whole lot worse.

Jim?

DR. MELIUS: Yeah. I have a question. This is related to that Working Group/Subcommittee issue, and it's really the first bullet up there. The Advisory Board would submit a task order request, along with the Independent Government Estimate. That's a new Independent Government Estimate, which means that that has to have -- well, that whole procedure really requires a meeting in person, and then a closed session, and you know, announcements and so forth, and I mean I think we have to factor

that into this decision on how to -- how to operate it. And so much of that depends on what the detail is of the task order; do we want to do a detailed -- I mean there's lots of ways we could do it, but -- but we do the elements of the task order through a Working Group or something, then the Independent Government Estimate is part of an actual Committee meeting. But if we're going to be doing a lot of task orders between meetings, it depends on the frequency of the task orders, then I almost would argue for a Subcommittee, which would allow you -- which would have to meet in person, but would be allowed to do the Independent Government Estimate. Is that -- that's my question.

DR. ZIEMER: Martha, you were going to talk to us a little bit, were you, about that Independent Estimate right now?

MS. DiMUZIO: Yes. I did just --

DR. ZIEMER: Give an example?

MS. DiMUZIO: But -- but Dr. Melius is correct, you would have to have some type of an Executive Session in order to develop that Government Estimate, whether it's a Subcommittee, or the full Board, or whatever, so --

DR. MELIUS: But -- but it can be done by a

Subcommittee?

MS. DiMUZIO: It could be done by a Subcommittee because the Subcommittee can act on behalf of the Board, correct, Cori?

MS. HOMER: They cannot act on behalf of the Board. Everything that is discussed has to be decided by the full Board, not the Subcommittee.

MS. DiMUZIO: Okay.

DR. MELIUS: That's what I -- that's what I want to make sure of.

MS. DiMUZIO: So basically it would be Independent Government Estimate associated with an individual task. What I did for, just for the sake of this meeting, is I just took the sample task, Attachment D, from the -- from the current proposal that we have and developed an Independent Government Estimate, you know, and --

DR. ZIEMER: This is a sample only.

MS. DiMUZIO: Yeah, obviously it's a sample only because I'm sure a Health Physicist --

DR. ZIEMER: Nobody should take the $2 an hour rate for a Health Physicist very seriously.

MS. DiMUZIO: That's right. So we just wanted the Board to see what type of information that needed to be included in -- in the Estimate as

it goes forward, so this is, you know, this is the type of information that would be required, so -- I'm sorry we don't have this on a slide -- but you would -- initially you would have -- the staff would be identified, and normally when you -- once the contract is awarded, the staff is usually identified, so you -- you may possibly be listing staff here by name. And then, obviously you would know what their hourly rates are and so forth; so, you know, you would total their salaries and their benefits to come up with the personnel costs; if travel is necessary, you know, we would add in those costs, you know, as required; any miscellaneous, you know, and that's postage, mailings, you know, anything like that; then the overhead costs that the contractor is charging, a subtotal, and then any fee, award fee, that the contractor is entitled to, to come up with the Independent Estimate and which would then be submitted to the -- along with the task order, to the Procurement Office for processing.

MR. ELLIOTT: Martha, I think I'm correct in this, but help me out. There would be a need to have two executive sessions on any individual task order, would there not? One to prepare in advance

the task order and the Independent Government Cost Estimate to be submitted to the contractor, then once you get the proposal back on that task from the contractor, it would require another Executive Session of whoever, the Subcommittee or the Board, to examine that proposal, deliberate upon the Independent Cost Estimate -- or the proposal cost estimate --

MS. DiMUZIO: Cost proposal versus --

MR. ELLIOTT: -- matching against Independent --

MS. DiMUZIO: -- Independent Government.

MR. ELLIOTT: -- and provide any negotiation points back to the contracting officer.

MR. DiMUZIO: I would -- I would give a qualified yes to that, only from the standpoint that it's possible that once you've received a proposal back from the contractor, you could say in a meeting that the -- the estimate was -- if you don't have a problem with the estimate, I don't believe you would need to go into Executive Session --

MR. ELLIOTT: Okay.

MS. DiMUZIO: -- to discuss the estimate.

MR. ELLIOTT: So the Board -- the Board or the Subcommittee of the Board could -- could specify

to the contracting officer that if the proposer's cost proposal is within or lower than the Independent Cost Estimate --

MS. DiMUZIO: Yeah, so --

MR. ELLIOTT: -- they don't have to have that yet.

MS. DiMUZIO: Right, so at a meeting of the full Board you could just say we -- you know, we accept the proposal, the cost proposal as submitted by the contractor, and you wouldn't have to go into what the Independent Government Estimate was.

DR. MELIUS: The second -- the potential second Executive Session, does that have to be the full Board or can it be a Subcommittee of the Board?

DR. ZIEMER: I think that's the same question, is it not, Cori?

MS. HOMER: Yes.

DR. ZIEMER: Decisions must be made --

MS. HOMER: Anything can be discussed by a Subcommittee as a full committee, or as you can a full committee, but anything that a Subcommittee does has to brought to the full Board for discussion and determination.

DR. MELIUS: So that would -- that means this process then, you just, the Board, we meet once

every six weeks, you're talking about a six week --

MS. MUNN: Hiatus.

DR. MELIUS: -- another you can add to this task order processing, what, at least another four weeks, I think, but, you know, on average if it has to be the whole Committee.

MS. DiMUZIO: Could you do that as a conference call?

DR. MELIUS: If it doesn't involve an Independent Government Estimate.

DR. ZIEMER: I think we already determined that a conference call for an Executive Session probably doesn't work, right?

MS. HOMER: It must be a secured call.

MR. ELLIOTT: It wouldn't -- a conference call wouldn't work if you had to have an Executive Session, but if you got around that, you didn't have to have an Executive Session to discuss independent -- discuss the proposer's cost estimate you could do everything you need to do by -- by teleconference.

DR. MELIUS: But you wouldn't necessarily know that until it was submitted.

MR. ELLIOTT: That's right.

MS. DiMUZIO: But I mean particularly in the beginning when the contract is first awarded, I mean

if it's possible that we have a series of task orders ready for when the contract is awarded, I mean you could have sort of one session where you reviewed several tasks at least to get the process started.

DR. MELIUS: I -- I think that makes -- obviously makes sense, but I'm just trying to figure out the alternative, and whether there is any other way of -- on that.

DR. ZIEMER: Which perhaps emphasizes the need to have some tasks ready to go at the front end of the process then.

DR. MELIUS: We'll have to agree to accept this rate of $2 an hour for a Health Physicist.

DR. ZIEMER: Okay. Any other questions for Martha on this issue?

Okay. Thank you, Martha, that helps frame out the time constraints or lack thereof that we have with this process.

DR. ZIEMER: Cori, do you have a comment?

MS. HOMER: Conference calls for closed sessions have been conducted by CDC conference call bridge, and that is considered secure. We'd have to double check and have absolute certainty, but I know that it has been done in the past and if others have

considered it secure, then it may be secure enough for our purposes as well.

DR. ZIEMER: Okay. Thank you.

Now, let's -- let's focus back now on the tasks before us. I'm -- I'm trying to develop a feel for how to go about this, and I'm not smart enough to have figured it out yet. It seemed to me that it might be helpful to look at the -- I'm trying to see which document it is -- the Statement of Work and the various types of reviews we have to do, or that we say that we would like to do, and try to get some ideas on the floor as to how we would carry those out as far as this Board.

MR. GRIFFON: Attachment C.

DR. ZIEMER: Attachment C, right. Attachment C of Draft 1/31/03, Request for Contract, and beginning on page 15 we have the Individual Dose Reconstruction Review; and then we have the Advanced Review; we have the Blind Dose Reconstructions; then we have the section on Site Profiles and so on.

It seemed to me sort of intuitively that if we could begin to address these maybe section by section, Individual Dose Reconstruction Review, let's take that as the simplest case. How are these to be carried out? That's not simply a rhetorical

question. I mean it is rhetorical at this point, but I think we now need to come to grips with that. And I -- I think it might be helpful, and I'm going to -- Mark, I'm going to put you on the spot and say okay, the Working Group sort of had a model in mind, and if you can remind us of that, and then let's take off from there and flesh it out a bit.

Well, the Chair always has the prerogative of getting other people to come up with the good ideas, right?

MR. GRIFFON: Yeah, I'm not sure. I think, Paul, what you're asking for is -- is assuming that we've selected the cases already, or do you want to back up and go into how we're selecting the cases?

DR. ZIEMER: I think we have to -- have to talk about that as well.

MR. GRIFFON: Okay. Okay. I mean --

DR. ZIEMER: In order to define the scope of what it is this Board is going to be doing because we're going to have to have task orders for all of this. Unless we can put it -- unless we can --

MR. GRIFFON: Right.

DR. ZIEMER: -- delineate it we can't write a task order.

MR. GRIFFON: Yeah, I think one clear place

we have to start is the selection process, and I think it might be -- we threw out some parameters in past discussions on how we would look at selection. We know a percentage of cases that we're going to consider. I think we also have to look at case availability, so this is hard to do without looking at the actual data base to know, you know, what cases are available for us to review -- you know, if you have a certain selection criteria, but there's no cases that fit into that realm in the first round of cases that are done by the contractor, then we're kind of sitting --

DR. ZIEMER: But see, you've defined the first step. Somebody is going to have to review the available cases, I mean maybe that's step one, right? And then we would say, and who is going to do that, is that the full Board or is that a subset.

DR. ANDRADE: Paul --

DR. ZIEMER: That's what I'm -- I'm trying to call out these issues. Okay.

DR. ANDRADE: I think this is a critical point for everybody to keep in mind as we go through this discussion, and that is that we have to all be clear, and be on the same page of music, by the way, on whether -- what you mean by availability are

cases that have been at least taken to the level of being sent back after the -- after the final dose reconstruction. Okay. Realize that all the language that's written here in the Statement of Work is in the past tense, and I think, in my own opinion, it was perhaps fortuitous that it was done this way, perhaps we just got lucky, that if -- if we recall and remind ourselves that it is done in the past tense, and we really will be developing a quality review process, we're going to be second guessing the dose assessors as they're doing the work then I think we will then be overstepping the boundaries or the intent.

DR. ZIEMER: I -- I believe, and others can correct me, it was certainly my understanding that this is an audit that's after the fact.

DR. ANDRADE: Okay.

DR. ZIEMER: It's completed dose reconstructions. Is that not everybody's understanding?

DR. MELIUS: Yeah.

DR. ANDRADE: Okay. Very good. I think that -- that helps.

DR. MELIUS: But I'm just saying, agreeing -- fully agreeing with that, but I think for the

purposes of this task or this selection we're going to have to be projecting out because of the time -- because of where we are now in the process because of the time frame going out, we're going to have to be able to project out numbers. We're not going to be actually doing selection, but --

DR. ZIEMER: But knowing what cases are coming down the line and some numbers of future cases will be selected.

DR. ANDRADE: If that's what you mean by availability then --

DR. MELIUS: That's -- that's -- yeah.

MR. GRIFFON: Yes.

DR. ZIEMER: But it's completed cases that are looked at.

DR. MELIUS: But -- but, and we are going to have some estimate of availability, but then when the actual selection takes place it will only be from the completed cases --

MS. MUNN: The available pool.

DR. MELIUS: -- the available pool, and do that, and we're going to have to probably recognize that our projections are not always going to be good because, you know, things get delayed or whatever, particularly as we get into some of the finer points

of types of cases from different sites and things like that, that's going to be maybe hard to fill. And we're going to have to have some flexibility in how these cases are chosen -- will be chosen at the time for review.

DR. ANDRADE: Absolutely. I think then almost by default we have solved, or probably come to a conclusion here about one of the bigger problems that was laid out even earlier, and that is the issue of conflict of interest between the administrative handling of this process by NIOSH and/or the Department of Labor. If this is -- is this is to be done after the fact, then there is no conflict of interest with the Department of Labor.

DR. ZIEMER: Are you saying the case would have already been adjudicated?

DR. ANDRADE: Absolutely.

DR. ZIEMER: Let me ask a question now, Mark. When you said identify available cases, you are suggesting these be identified generically by type, location, or what? In other words, I'm asking you is this something that could be done as you're saying, in open session, we're not identifying individuals; you may identify sites, types of cases, numbers of cases, something that --

MR. GRIFFON: Yeah, I think --

DR. ZIEMER: -- can be done by the full Board --

MR. GRIFFON: Right. I think --

DR. ZIEMER: -- in open session that we say okay, at this meeting we've set aside some time -- I mean I could see at each Board meeting having some time set aside where we do this.

MR. GRIFFON: Yeah, generally I think so. I think we can discuss some, we've already discussed some potential parameters, you know, but we -- we didn't get more specific than that. I guess the question I was running through my head was -- and it depends on how we lay out this task order -- but if you have a task order to be completed in one or two years or whatever, you estimate a budget for the first year, and based on our sampling scheme there's no cases completed that meet those criteria, then we, you know, we failed. So we've got to project and that might have, you know, we'd have to work with NIOSH to see, you know, maybe by -- by finding out what they have in the hopper, what they're working on, you know, the -- you know, just as an example, if they were doing all Hanford cases first, I know they're not, but if, you know, they were

doing all Hanford first, then, you know, our criteria is, you know, we're not meeting all our sampling criteria, so just projecting like Jim said, the numbers.

DR. MELIUS: My thinking, that would be a task for a workgroup to do, and come back to the Board with sort of the parameters of that, you know, the task, based on where we see NIOSH is, and what NIOSH is projecting, a number of other, some of these (inaudible) -- there will be so many cases available for, you know, completed cases available within this time period for review. And that to me would be something that could be probably better done by a workgroup talking to NIOSH. Then maybe an affirmation of that, or even the final selection be done by the, or which could be done and I think sort of very easily and naturally as part of this task order development.

DR. ZIEMER: We're just getting ideas on the floor now.

DR. MELIUS: Yeah, yeah.

DR. ZIEMER: We have not approved workgroups.

Tony.

DR. ANDRADE: Okay. Then I have a question

of Jim. Jim, to the best of your knowledge, in the cases that have been reviewed, some preliminary dose reconstruction done, or perhaps even finals, even though you describe your work as having attacked those cases that are quote, low-hanging fruit at this particular point in time, do you believe that you have a good representative sampling of a wide variety of cases?

DR. NETON: With a sample size of 18, I'd say no. Eighteen out of 10,000, so. But we do have a couple of different approaches that one could look at, but obviously there's -- there's a number of things like AWE's and such that would not be included.

DR. ZIEMER: Keeping in mind that this process may be six months off before it gets underway and looking what's in the pipeline, I think the sense of the question is how representative and what -- what we have now that's coming onscreen in the next six to eight months, how representative is that?

DR. NETON: I think -- I think Mark Griffon hit it -- hit it on the head. The Board needs to work with us and the ORAU contractor to determine what the plan of attack is for the upcoming six

months to a year, and then develop a sampling schedule based on that. I'm not convinced with the task order you really need to identify specific types of review. I mean you're really just talking about numbers of reviews period, and you don't really need to get that specific I don't think.

MR. GRIFFON: Yeah, the only thing I was thinking, Jim, is that if we do specify a number of reviews and then given the criteria we've laid out --

DR. NETON: Yeah.

MR. GRIFFON: -- we're overwhelmed with one type of case --

DR. NETON: Right.

MR. GRIFFON: -- but we don't have any of the others, then we, you know.

DR. NETON: But I think there were complete -- wasn't it just like advanced versus basic. I mean it didn't break it down into compensable versus noncompensable.

MS. ROESSLER: No.

DR. NETON: So I think you could, you know, the sampling strategy is you're going to take a certain percentage of those and do an advance review, so if we predict that there's going to be a

thousand cases --

MR. GRIFFON: But you're -- you're also looking at the types of review versus the parameters by which to select cases, and those are two different things.

DR. NETON: Yeah, and I've forgotten what those were.

MR. GRIFFON: I mean the -- the parameters we were thinking about were -- were site, complexity, the -- the --

DR. NETON: And I think we're far enough along where we could work with ORAU and develop a sampling strategy for the -- the sites that may be coming through, but based on the -- it's really now being driven by the completion of the site profiles, that's sort of the limiting factor at this point. Once you have a full set of data on someone and they appear to be noncompensable, if you don't have the complete site profile in place, it can't move forward, so as those site profiles become completed at least for certain blocks of years, we can give you an indication of which cases will be moving forward in fairly large chunks.

DR. MELIUS: Two things; one is just a follow-up to that. I think you said you were doing

a first-come-first serve, you know, in the order that they were received, so, you know, from taking into account these other parameters like site and profile, I think you could, with some time and effort, sort of figure out how to do it. And I think that would be a way, and then you're just going to be estimating what's going to be a complete case, available case at some point down the road or within a certain time period. I also think, though, we have to be careful that we may have a general sort of task order in terms of -- it wouldn't specify the cases, but we also have to work out a procedure for how those actual cases will be selected. I mean we don't want to put us in the position of having -- or put NIOSH in the position --

MR. ELLIOTT: We're not going to select them.

DR. MELIUS: Yeah, you're not going to want to be in the position of making the selections, so.

DR. NETON: If I could point out, just make -- Martha can correct me if I'm wrong, but I think if you write a task order for a certain volume of work or it ends up being adopted, you can always extend it. If you don't complete that work in that

given contract year I think we have the option to just say okay, we'll carry this over in subsequent years.

MS. DiMUZIO: Right. What I was going to say is that, you know, you can say that --

WRITER/EDITOR: You need to use the mike.

MS. DiMUZIO: The task order can say that you're going to review the cases; you want the contractor to review 70 cases over the year. That doesn't mean you have to have those 70 cases identified at the start of the task order. You could, you know, you could look at the matrix or, you know, give NIOSH some type of guidance on what your matrix, you know, of what you'd like to look at, and we can see how the matrix is and what type of numbers that you're looking at. So you don't really have to, when you assign the task order, at that point in time, know exactly what the cases are. You know that you want the contractor to review 70; you could give him 10 now, you know; 50 in three months, you know, cause you're going to give them, you know, however long; you want 70 cases in a year, so you would probably do a task for one year for those 70 cases. So you really don't have to know upfront prior to award of that particular task

exactly what those tasks are.

DR. NETON: We could always add or --

MS. DiMUZIO: And we could always modify. Yes, we could add time to the task if we realized we didn't get the right matrixes that we wanted or reduce time and reduce the number, and then, you know, reduce cost or something like that, so.

DR. ZIEMER: Just one second. I want to capture a thought because I think, Jim, your comment moved us to the next item after availability, but I can't remember what you said.

DR. MELIUS: On the case selection.

DR. ZIEMER: Case selection.

DR. MELIUS: Yeah, and if I can --

MR. PRESLEY: Go ahead because that was what I was going to talk --

DR. MELIUS: Well, my -- it was this workgroup -- if we did this sort of workgroup, it could also be not only work on the parameters of this task order, but also a case selection, specific case selection process; how are we going to select cases and meet these parameters, and what's an easy way of doing it without having to, you know, wait until the cases are through the process.

MR. GRIFFON: Yeah, how --

DR. ZIEMER: Well, by case selection you're identifying them by sort of generic features, not by --

DR. MELIUS: And then we'd also --

MR. GRIFFON: We're talking stratified sampling, I guess, yeah.

DR. ZIEMER: Yes.

DR. MELIUS: Then how will the actual cases, a process for how the actual cases will be selected once they --

DR. ZIEMER: Right. I'm just going to jot down as another case selection process is the issue. Okay. Now, Robert.

MR. PRESLEY: Well, when we started the working group we started talking about a percentage, and then we went off and talked about looking at the highest number of cases from a given area being the highest that we would do, and then go back and look at the AWE areas, maybe the AWE areas where we were having the most trouble, and try to pull some of those out to see if everything was according to all there. And that's some of the things that we have talked about in the past is maybe taking a percentage --

DR. ZIEMER: And again, that probably is

part of the case selection process.

MR. PRESLEY: Right. And that will be part of the case selection process also, to intertwine.

DR. ZIEMER: Right.

MR. GRIFFON: You know, just for your information in those overheads there is -- there is page 4 -- yeah, the July overheads behind the three contract parts. Page 4 has a couple of overheads on case selection and stuff that we had talked about in the working group preliminary stuff. And I think what we're talking about as far as stratification is the -- the second bullet of the first overhead there, it talks about some stratifications we were considering. I'm not sure that's all of the appropriate ones, but that's what came out at the time.

DR. ZIEMER: Very good. Okay. Who's next? Case selection process as you have it here gives some of the parameters: the site; the exposure type; cancer type; and so on. It gives the percentage of cases, but I assume, Jim, that you were talking about a little more specificity beyond this --

DR. MELIUS: Oh, sure.

DR. ZIEMER: -- even the actual process now.

DR. MELIUS: I think there are like three levels to this. One is an estimate of numbers that would be appropriate for the task order, given our overall sampling scheme, whatever we want to call it, for case review. Secondly is a way the group could work out how would the cases be selected, a procedure given the data base, given how things are being processed and so forth, a way for -- a method for case selection. And the third thing is the actual procedure, the actual selection of the cases. Now, that may be a separate, because that's after the task order is awarded and we have to decide is that something that the Committee does, is that something the Committee has to do, which many of these things seem to be, or can that be done by -- will we have another workgroup that would do -- be tasked just to do that, and is that appropriate.

DR. ZIEMER: And that, in fact, is one of the issues that we have --

DR. MELIUS: Yeah.

DR. ZIEMER: -- to decide.

DR. MELIUS: Right.

DR. ZIEMER: Well, given that we're going to do 37 cases of something or other, how are you going to actually choose them?

DR. MELIUS: Yeah. Right. A procedure for doing that, and then third, just actually implementing that at the time when it needs to be implemented. And I don't think that is something that's easy to -- that we should be, in fact, delegating to NIOSH or whoever is doing the contract, or do they want to be involved in that part of it.

DR. ZIEMER: No, that's -- that's a Board activity purely under this particular task.

DR. MELIUS: Yeah.

DR. ZIEMER: Once the -- once the cases are selected, and we have identified the cases available and we have a process in place we've agreed to, that's sort of a one-time thing, but it can be tweaked as you go along. We have a procedure for the selection of cases, and now you have before you X number of cases, now what happens?

MR. GRIFFON: Now --

DR. ZIEMER: Okay. I mean we know conceptually what happens, I want to know what really happens.

MR. GRIFFON: Oh, what really happens, I mean it does depend on the type of review I guess, but if you had a pile of Basic Reviews --

DR. ZIEMER: Let's start with Basic Reviews.

MR. GRIFFON: Right. Well, I think first, you know, there's the question of how this material can be delivered to the auditor; whether it has to be D-identified and I believe it has to be D-identified, so whatever cases we select are D-identified, and then for the Basic Review I think we're only looking at the -- I'd have to go back to all these detailed, all of our parts of the Basic Review, but I think one's first step would be that the auditing contractor would get a disk copy, or whatever form, from NIOSH of the D-identified version of that case, the entire administrative record, along with, I guess, the final decision for the Basic Review because they're not going to -- it's not a Blind Review, they're going to see the -- that's one starting point I can think of is that they're going to get that.

DR. ZIEMER: And Jim, if -- Jim Neton, if you have comments to add to this, jump in, but I'm trying to get at questions like: Is this delivered to an individual who is the contractor? Is this delivered to a Board member, through them, in consultation with the contractor does something -- I mean at some point we've got to get very specific

what happens. And we're not going to solve this all today, but I want to get these questions before us, so we -- we have some direction as we go forward. We may not even be able to finish this tomorrow, but we need to start framing out the process, and try to identify -- and we may have to have a working group actually step through this and make some block diagrams. But it's almost like a paper flow thing.

MS. MUNN: Yeah, it is. Yeah.

DR. MELIUS: I also think that some of us, because I think the question comes up as to what this whole (inaudible) Board members are involved in each individual review.

DR. ZIEMER: That's exactly what the question is. We can't just -- we've got --

DR. MELIUS: But -- but --

DR. ZIEMER: -- that's floating around here. We need to --

DR. MELIUS: But that's also going to be dependent on what the flow of cases is, the task and the issues we've just been talking about, that if there's a large number of cases early on -- for example, I could see where we set up the process so that Board members would be more involved early on, so that we get more familiar with the process, and

so -- and then as the reviews go along the Board members might want to be less involved. But all of that is going to float or, you know, involve how many cases there are, how much work there is, and to do with --

DR. ZIEMER: Obviously we can modify this as we gain experience. We're going to be operating sort of like Jim has been, as we gained experience we'd start modifying. But you have to have a starting procedure, so you have to have something to modify.

MR. GRIFFON: I guess the initial scheme was to have Board members working with the contractor, some sort of panel, and how that's constructed, you know, if we had designated assigned panels, I'm not sure that's going to work for people's availability and things like that.

DR. ZIEMER: And we have to think about --

MR. GRIFFON: Right, yeah.

DR. ZIEMER: -- availability, and where is this going to occur physically --

MR. GRIFFON: Right.

MS. ROESSLER: Yes.

MR. GRIFFON: Right.

DR. ZIEMER: -- are people traveling

somewhere, or --

MR. GRIFFON: Right. Now the model we had discussed we had discussed in the working group -- in the previous working group was to have the -- the idea was to have the panel -- actually, I think I put it in some of the estimates and stuff we talked about. The Board members that were on the panel assigned to those reviews would -- would plan on coming to the Advisory Board meeting a day early or something like that where they could meet with the subcontractor and work through and see -- and we're really relying on the subcontractor to do a lot of the detail work. I would think as far as documentation though, like the administrative record or whatever for cases that are being reviewed my notion would be that these things could be mailed. I think that's -- that would be legal, so I could see CDs going out to the contractor and to the panel members for that -- that were responsible for that case. And maybe some process has to be worked out that they be returned back to NIOSH at the end of those case reviews, I don't know what the rules would be there, but, you know, I don't see that you have to physically come to -- everybody would have to physically travel to NIOSH to get these cases and

sit and review them all at once. They could have them back at their offices and collect it at a -- and come back to a meeting to collect it, especially for the Basic Review, which is the lower level review.

DR. ZIEMER: Robert?

MR. PRESLEY: If everybody got a CD, the two-person, three-person, four-person, five-person, whatever the panel is; we had talked about coming in a day early, the panel, taking the instruction from the contractor, and if everybody said that was fine, then we would come in front of the Board, the full Board and say, this panel recommends that this dose reconstruction either be accepted or rejected at that time. And if it's -- I see it as accepted, it goes; if it's rejected, then we've got a problem.

MR. GRIFFON: And what I could -- the way I saw that panel working there is that if the contractor came back in and we try to do it sufficiently so that we could have maybe, you know, five, ten, whatever number of cases that we can look at at one time, not just one case at a time; you look at five cases and maybe you say well, four of these we're in agreement with you, we're going to present that to the Board, the overall Board, and

the Board can rule on it. But one, we'd like you -- we have these questions, and we told the contractor to give us some more information and, you know, do some further work on this one and report back to us at the next meeting, you know, something like that might evolve, that way the panel is digging into the cases a little deeper than the overall Board, so that's kind of how I envision that working.

DR. ZIEMER: Other comments at this point?

DR. MELIUS: Also, I think you have this process sort of practically that maybe it's a series of there's a workgroup appointed that's panel one; panel one meets between -- before meeting one; reports back -- we're not going to have, you know, I don't think four panels meeting before each meeting, so it's going to be done sequentially. Now, panel one, if we follow Mark's sort of protocol here, panel one may have some leftover cases that aren't resolved by -- by meeting one, so those would be deferred to meeting two, and panel -- you know, and I -- and those are hypothetical, I think we still have to work out the logistics of -- of how that would actually occur. And then also, these type of reports get, you know, what are we accepting at meeting one, or do we really have to have panel one

meet before the meeting -- before meeting one, so that there's really time for a report because I think we need to be accepting a report on the -- I mean the full Board has to approve a report on accepting a report on this. And then have some way of summarizing that, I think, of that review process which is really an overall Board function. I would presume we would do that with the help from the contractor, but.

MR. GRIFFON: What Jim just said was -- it sort of summarized our conversations where we talked about these rotating panels, and I think that does make sort of sense that at each next meeting we might want to then say okay, we've got these cases up and running and we need a panel to work -- for the next meeting to work with the contractor on these certain cases. I think we might have to do it like that because then -- then Board members could decide, you know, who is available; secondly, there might be conflict of interest issues where we can't review certain cases because of our personal backgrounds, so we could assign panels sort of at each meeting, sort of ad hoc selection of those panels moving forward.

DR. ZIEMER: When you say rotating panels,

there wouldn't be a certain panel that's always made up of the same combination of Board members, it may be some --

MR. GRIFFON: That's sort of the way I would, yeah.

DR. ZIEMER: Roy.

MR. DeHART: I think we had talked about in the group a panel of three basically trying to meet together, but that could be changed of course. What I would like to see us flesh out a bit is -- is what's happening with the panel when it meets with the contractor and what, as Jim has implied, what is the report. I had not envisioned a great report coming out -- out of that. The effort was to look at the work that had been done by the contractor and if there is agreement, that's it. And if there is issues, then it's back to the contractor to rework until there is agreement, and then presented to the Board. But from what Jim was saying it implied some report of depth might be coming out of that.

DR. ZIEMER: Well, part of what you're raising, actually the question: What is the nature of the report that comes out of the panel? I think that's a very important part of the audit. It's not necessarily the issue of should compensation have

been paid or not, it may be the issue of -- and the bottom line might have been correct, but if we start to see things like incorrect assumptions are being made, or unsupported assumptions are being made, or something like that, then you start looking for patterns. So it seems to me the report has to be dealing with the nature of what's being done and how well that is being done. Certainly part of the bottom line is, is the correct decision made. But we're not sending things back for redoing of the decision, we are looking for -- and you might actually, I guess, conceivably have a case where you say, you know, this person should have been paid off and they weren't, in which case you might actually have a way to reopen it, but that's a separate issue, but if -- if your finding some flaws in the methodology, I guess is what you're looking for. And so we may have a series of things, and I'm trying to remember if you addressed this. Is the report -- or was the dose reconstruction, were the assumptions valid --

MR. GRIFFON: Yeah. Yeah, we have it in there.

DR. ZIEMER: -- was the site information data properly used -- weren't there --

MR. GRIFFON: Yeah. Oh, yeah, they're all -- they're all in there.

DR. ZIEMER: They're in there.

MR. GRIFFON: I -- I guess I envisioned this report as being --

DR. ZIEMER: Well, that would be the basis of the report, would it not?

MR. GRIFFON: Yeah, I guess I envisioned this report being fully developed when the contractor came to these panel meetings. And the notion of the panel at all, I mean you could say well, why have the panel. I thought the intent of having the panel was that they would get the CDs ahead of time with all this data that the contractor is reviewing, and would have access to the contractor doing that review via phone, most likely. But they could have access by e-mail or phone, you know, to ask questions are you looking into this, or whatever. Then when the contractor comes to meet with the panel the day before the Advisory meeting, they'd go through their entire report, and if I'm on the panel I can say well, you know, wait a second, I was looking at the administrative record and, you know, these pages, you know, I don't see you really addressing this issue in your report at all, you

know, so the panel members have had -- have had more time to review the specific cases, and then they can -- they can, you know, they don't replace the Board's vote, but they'd have more time, you know, and the Board -- it was just to alleviate from having every Board member review every case, you know, so.

MR. DeHART: Let me give you an example of how a review might happen. We deal with medical records; we have a checklist basically that we just go down and make sure that you know there's a name, and there is a diagnosis, and evaluations, and a proper treatment appears to be made; boom, boom, boom, we'd check it off and if that's it, then this one would be completed in terms of its review and recommended to the Board. But if there's problems, we would address those and ask the contractor to try to make those changes.

DR. ZIEMER: Thank you. Tony, and then Jim.

DR. ANDRADE: Given what's in the definition of Basic, Advanced, and Blind Review Requirements, I believe that answering the questions or addressing each and every specific item there, even in a view graph, would comprise a report. But if we have a panel to check the quality of the auditors who are

checking the quality of the contractors, then I think we're going to be duplicating efforts and wasting time, so if the panel convenes to insure that these things have been done in a checklist method, then I think that would really be all that is necessary and probably minimize people sitting on a panel's time and effort.

DR. ZIEMER: Jim. And then were you going to respond to that, Mark?

DR. MELIUS: If you want to go ahead, you can.

MR. GRIFFON: No, go ahead.

DR. ZIEMER: Jim.

DR. MELIUS: Yeah, I would see this working off of form and I -- and I think it would behoove us as a Committee, so perhaps we develop the form so we can -- cause we have to give that at the time these task orders go in place, and we don't want to make that the first task order or we delay the whole process, so we can't let the contractor do that, so that's one. And I think the issue only comes up -- there's an issue that would come up, it may not always come up, but would come up if we find a problem or a potential problem. That's when there's the issue of the report and maybe it's also when the

Advisory Board member would sort of get more -- we'd have to judge how serious this is; is it a pattern, and then there would be a need to be some report from the panel that would say we have reviewed 10 cases, whatever it is, that we found problem A, and we'd have to have some way of putting all those panel reports together, you know. And it may be that the kind of problem that may be found may be only serious if it's a pattern or, you know, there's lots of different ways to characterize that. But I don't see us doing large reports or long reports on each case or anything. It would -- it ought to work off of form, and I think we have to spend the time developing a comprehensive or a complete form that we're satisfied with.

DR. ZIEMER: Thank you. Mark, you were going to respond to Roy's comment, or Tony's.

MR. GRIFFON: I was.

DR. ZIEMER: You were.

MR. GRIFFON: I guess that's why I let Jim go first because I was pausing on this one, but I -- you know, I don't -- the intent of the panel, certainly the reason we're looking for a contractor for this Advisory Board is to pull expertise into this Board to actually do these reviews. On the

other hand, it is the Board's responsibility to do this -- this oversight task, so we are responsible for these findings, so I'm listening to the checklist comment and, you know, I'm thinking of the model on NIOSH's side, which is that, from what I understand NIOSH has -- ORAU is doing the bulk of the dose reconstructions; NIOSH is reviewing every single one. I think that we're having a contractor do all the dose reconstructions. I don't -- and it wouldn't be as extensive of a review, but I think -- maybe a checklist is enough -- but I think there's got to be some sort of review by the panel just to make sure that the Board is comfortable with the final product.

MR. PRESLEY: Mark, isn't that what we're going to do on the Blind ones?

MR. GRIFFON: Yeah, I haven't got that far.

DR. ZIEMER: On the general review, certainly it was my understanding that we're not recalculating, we, the Board, we're not doing dose reconstructions.

MR. GRIFFON: Right. But I mean I -- I guess I just envisioned it as being -- the panel members involved in it as being more than our -- the Board's contractor comes back and we have a

checklist that says they looked at basic review items A-1, check; A-2, check. I mean I think the panel should -- should look at their report and -- and make some kind of determination as to whether they -- the contractor addressed it adequately for -- for the Board to make their final decision as to whether the whole case was reviewed appropriately, you know. That doesn't mean that they start from scratch and do all the work the contractor did, but.

DR. ZIEMER: Okay. We have a comment from Mike, and then we'll get back to Tony.

MR. GIBSON: I guess Mark was kind of addressing what I was thinking, is, you know, if we have rotating Board members for different cases, each one of us will probably have a different idea of what's an acceptable site profile; what's acceptable default parameters; so it looks like to me it could keep us from being consistent if we just have a basic, generic form that we check off unless we really define, as a Board, what adequate site profile, you know, which gets us into another level of the work, so.

DR. ZIEMER: Keep in mind we're -- we're really not asking quite the question of what's an adequate site profile, we're more asking something

along the line: Did the dose reconstructor use the information properly in reconstructing the dose? Many of these site profiles may indeed be inadequate from one point of view, but may be adequate for doing a particular dose reconstruction, so some of these -- some of these questions, you know, have to be answered in the context of particular cases so that if there's -- if there's an issue with a case, then you raise it and say, you know, they made some assumptions here that you can't make based on what's available. And I think you're quite right, Mike, that you may have a better feel in some cases for whether that's the right, and I think the Board does bring its view to the -- to the process. It's very interesting, just -- I just talk generically, you know, Boards nowadays are getting a lot of scrutiny, particular those that have audit functions. I'm on a -- I'm on a different Board right now that is setting up an audit committee to audit the auditors, and you know why that's come about. But there are Federal Regulations now that Boards have to audit their auditors, and it's -- the auditing function of a Board Audit Committee is not one of doing the audit. They are looking to certify that the auditors followed the proper audit procedures that

they say they're following. There is a point at which you have to take people's word when they say I did this, and they show you how they did it, you know, somebody can still fool you, but since the Arthur Anderson case has come about, you know, there's -- people are checking the auditors. Now, Boards even have to determine whether their auditing committee is properly auditing the auditors, so it keeps moving back a level. But I think there is a sense in which we have to take the responsibility as a Board to do this function. We -- we are -- we are doing an audit, and it's not our contractors, they are helping us do the audit, but you're quite right, it's our responsibility; ultimately if there's a problem, it falls back on us.

I'm off my soap box, and who is next? I think Tony was next, and then Jim.

DR. ANDRADE: Again, I envision the report, or a report to a panel, whatever body, to be -- to include statements and/or groups of statements that address the various elements that the contractor was assigned to do; whether it's basic, advanced, or blind. So it's fairly simple insofar as what content should be -- should be there. If the -- okay, let me -- let me digress to an example and go

back to the example that Mike used that we may be uncomfortable, or one of the panelists may be uncomfortable about the adequacy of a site profile. Well, the nice thing about the way the system is functioning is that inadequacies usually lead to greater uncertainties in dose reconstructions; therefore, inherently the system self-corrects. In other words, it becomes more user friendly as the uncertainty grows, and that can be pointed out; that can be information that's fed back to the -- to the associate universities, etcetera, so I think that's a self-correcting sort of issue. I just wanted to mention again these contractors here are incentivised through the contracting process itself. In other words, they're being paid to find mistakes, to find errors, to find shortcomings. That's where -- you've got to keep that in mind as well.

DR. ZIEMER: I'm not sure we pay any bonuses if they find one.

DR. ANDRADE: No, but -- but there are reasons why these people are bidding, okay, and so let's not forget that.

DR. ZIEMER: Thank you. Jim, you had another comment.

DR. MELIUS: Yes.

DR. ZIEMER: Then we're going to close it off for now.

DR. MELIUS: Okay. I think we could develop a form based to some extent on what we've already written here that would be used by the contractor in doing the review, used by the panel in meeting and discussing that review would capture that information, and something that I do agree with Tony that we're going to -- they are going to be finding things, and I think the part of the panel function is going to be sort of determining how serious that is, understanding that -- that, and then making some sort of assessment out of it, and then we have to, as a panel or a Board make an overall assessment of that. But I think if we get into forms that we're all comfortable with, I think that we can make the process work without, you know, generating a lot of paper that's not useful or putting too much of a burden on us to do the actual dose review. And it is quality assurance, and so it will actually, I think, tend to find problems or potential problems.

DR. ZIEMER: Thank you. With that comment we're going to end the discussion on this topic today. We will be back to this topic again tomorrow.

We do have on our Agenda a Public Comment Period. We have several individuals who have requested their time to comment. We will begin with -- let me see if I can pronounce these right: Is it Hans Behling, S. Cohen & Associates. Hans, did I pronounce your last name correctly?

MR. BEHLING: Yes.

DR. ZIEMER: Thank you. Please come and address the group.

MR. BEHLING: I really don't have as much of a comment as a question, and the question -- there's two questions that somewhat relate to each other and they do involve a NIOSH/IREP dose model, and perhaps somebody here in the Advisory Board can answer the question.

When you talk about internal exposure from, let's say a rem of 31, the issue in the scientific literature has been based regarding the efficacy for a unidose of internal radiation to include thyroid cancer as opposed to external radiation. In other words, a rad is a not a rad, it is not the findings in the external or internal, and the ratio between the efficacy of internal to external has been in the scientific literature defined as being a part, it's a part of 10 to 1 or -- or essentially 1 to 1. Does

the particular IREP model address that issue of efficacy once the dose for internal and external exposures to the thyroid has been added to each other? That's my first question.

DR. ZIEMER: We can probably have Jim Neton answer that. Go ahead with your second -- or Jim go ahead and.

DR. NETON: I'm not sure I really understand the question. You're talking about external exposure in a gamma radiation field added to some internal exposure from like the data radiation that one might receive, something like that?

MR. BEHLING: In terms of the PC calculation, if one say had external, whole-body exposure that includes the thyroid, let's say if 10 rads or rem, and then from an internal exposure to ion like 31, you also have 10 rems --

DR. NETON: Okay. Yeah.

MR. BEHLING: -- and how are they added to each other, and what is the efficacy assigned to internal in terms of risk coefficient for the private citizen?

DR. NETON: Okay. The answer to the first part of that question is they are treated totally independently; IREP allows for input for both an

internal dose component and an external dose component; it's on an annual basis. I don't know the exact value for the risk coefficient for internal versus external, but the external was modeled after the Hiroshima-Nagasaki survivors. The internal risk coefficient is also modeled after the Hiroshima/Nagasaki, but the dose calculation is not. I mean that's done separately using the ICRP models, so the answer is we do account for both internal and external. The efficacy model though, the risk coefficients though, once the dose is calculated is based on an external -- well, that's not true -- there is -- there is some medical studies, or a few medical studies that were incorporated into developing that risk coefficient, and I guess I'm not sure exactly how much weight was given that. I'd have to look into that to get back to you.

MR. BEHLING: The second question is also an important one related to iodine and the potential thyroid exposure. We all know that the uptake fraction, that is the transfer from blood to thyroid for iodine is heavily dependent on a dietary intake of cold iodine. In other words, a person, you have two people; one takes a dietary iodine intake of let's say 300 micrograms per day, and the other

person only 100 micrograms; expose those same two individuals with all other parameters being equal to an airborne environment or ingestion; the person who has a lower dietary intake has a higher FS-2 or uptake fraction, and as opposed to the person with the 300 micrograms. Now, we do know, and I've done a lot of work on this area, that the dietary intake of iodine has shifted over the years since the introduction of iodized salt. Also, there are geographical differences that separate East Coast, West Coast. The most recent data I've seen is that West Coast people, on the average, may be consuming up to 700 micrograms of iodine a day, which will certainly impact the -- the FS-2 fraction for thyroid doses. And so we have a variation here over time and space that deal with the dietary iodine intake that has a pronounced effect on the actual dose calculation. What is the issue that will be addressed on that level?

DR. NETON: That's a difficult question, but the answer to that is that we use the standard default ICLP metabolic values for -- for uptake of iodine. I guess in just quickly thinking about your comment, those that were rich with the iodine -- diets were rich in iodine we would be actually

overestimating their dose. Those that were deficient, we would be underestimating, but I don't think that we really have any way of reconstructing -- a good way of reconstructing their iodine intake at the time of the occupational exposure. This is the non-environmental exposures, so the answer -- we don't address it, we use the standard default; however, models do allow for us to incorporate uncertainty into the dose calculation itself. To my knowledge, we have not done an iodine exposure dose calculation yet, but we certainly could incorporate that into the uncertainty in the dose dosimetry.

DR. ZIEMER: But keep in mind also, in the case of occupational workers you -- you may actually have thyroid uptake measurements, which give you the actual burden of iodine in the thyroid, so you -- you don't have to depend on any metabolic models for those. And many of the facilities using iodine would have that. I'm not sure about the older cases, but --

DR. NETON: That's a very good point. If -- if the exposure got to the point where there was a significant dose of thyroid, a person, not more than likely, but probably could have been -- would have been monitored and we would have the exact value of

a good approximation of the iodine in their thyroid. For those lesser cases, we tend to be very conservative or claimant favorable in our approach, and we'd certainly more than likely overestimate the amount of dose to the thyroid.

DR. ZIEMER: Thank you. Any of the Board members have questions on this issue?

Okay. Next we will hear from Denise Brock with United Nuclear Weapons Workers of the St. Louis region.

Ms. Brock.

MS. BROCK: Hi. I'm Denise Brock, and I'm going to read from this because I'm extremely nervous.

I am from St. Louis, Missouri, and my father was Christopher Davis. He was an employee of Mallinckrodt Downtown Destrehan Plant for 16 years. In 1967, he was diagnosed with lung cancer and after a complete pneumectomy, and years of suffering, he passed away.

My mom, Evelyn Coffelt, is 70 years old. She is a claimant and she filed two years ago. Up until about a month ago my mom worked full-time just to make ends meet, but due to failing health she has been forced to quit her job.

My mother is living barely above poverty level, and I was hoping that her claim would be handled expeditiously, and that she would be compensated. I am here on her behalf and on behalf of all of the Missouri claimants.

Prior to coming here I had called two meetings; the first consisted of about 60 people, which kind of surprised me, I thought I'd end up with about 15 or 20; and the second, I actually had over 300 people, including Congressional staffers and Federal Officials. And one of those Federal Officials is here today; Dr. Jim Neton, and I would like to thank him publicly, now, for attending; as well as stating that since listening to the discussion today I feel confident in going home knowing that there's an honest effort being put forth by this Board to wade through all of this. It seems to be kind of public opinion from the claimants that maybe they're not going to get paid, and I think sitting here listening to this just shows me that everybody is putting an effort forth and that it's -- there's a lot of intricacies in this.

I would also like to commend the Paducah Resource Center; they have been a lifeline for

myself and the claimants.

Since my second meeting, I have been contacted in excess of over 600 people, and that's not including members of the press, the media, and even Erin Brockavich's office. Throughout the contacts of the claimants though, I've noticed that we have all similar statements, concerns, and questions, and in reference to that I have some issues that I'd like to raise with the Board, all of which have really been touched upon today.

Number one would be the quality of the -- and I say transcripts, but I'm understanding that would be drafts pertaining to the phone interview. For example, my mother had her phone interview on December 12th, and I did record this. It's my understanding that the phone interview is a very integral part of this program, especially dose reconstruction. Knowing this, I have done a tremendous amount of research concerning the facilities. At the beginning of the interview the interviewer's computer went down; she was very nice and very polite, but she did assure me that she could write as fast as she could type, so I continued, and as I said before, I had quite an enormous amount of information about these sites.

This time, because it was about my father, I was talking about the Destrehan site, and they worked with Belgian Congo pitchblende. This African ore was so hot that the workers were exposed to not just U238 and it's daughters, but U235, which I understand is rarely found in nature, and all of its daughters; thorium, all three types of radon gas, three types of radium; and I kind of went through all of this with her, even in reference to like the work environment. As I continued, the interviewer conveyed that the Health Physicists were aware of all that the plant consisted of, and felt confident in summarizing. And typically, one might be comfortable with that, but I have heard repeatedly from claimants and other sources that the data is still being recaptured, and that there might not have even been a site profile done yet. My question is: Was she correct -- is the interviewer correct, would it -- has there been a site profile done, and do they know everything they need to know, or on the flip side, maybe would that be incorrect, and maybe she would be remiss in taking -- not taking down everything that I had stated to her?

DR. ZIEMER: I'm wondering if any of the NIOSH staff are able to answer that, and if not

right now, they will certainly be able to shortly.

DR. NETON: Yeah, I think I can address that partially anyways.

It sounds like -- let's go back. The interview is really to try to elicit the information that's specific to the claimant that may not be known about their exposure scenario, you know, where they worked in the plant, what type of material the claimant worked with individually, so that's really one of the -- one of the main intents of the -- of the interview itself. If a claimant does have site-specific information they developed on their own that is somewhat voluminous in nature, that should be provided to us; it could easily be provided to us under separate cover, but it really is not the intent of the interviewer at that point to go over and develop site profiles during the interview. So I think maybe we have a little bit of misinterpretation of what the interview is actually accomplishing. Do we have site profile for Mallinckrodt done? No. I mean we're working on it, there's a lot of information we have, but there's a lot we don't have. Anything that you would have or a claimant, related to the Mallinckrodt site, we would encourage that to be submitted, and that's

more than likely what the interviewer should have said, is, please, you know, submit that under separate cover, when it's a volume, if it's not meant to be taken down on the telephone. Anything that is specific though to the claim itself, it could help elucidate the actual dose to your father would have been of value, and it --

MS. BROCK: He had three separate job titles --

WRITER/EDITOR: Use the mike, please.

MS. BROCK: He had three separate job titles, so I'm assuming, and I actually had which plant he was in like 4, 6, and 7, those different areas, so if I was being specific with what were in those areas, would that have been something the interviewer would take down? I mean I'm just confused, or do I send that in with my hard copy?

DR. NETON: No. If you knew specific job titles, and locations, and type of materials, which are actually part of the interview. I mean that is the script the person should repetitively go through, and that's why we computerize it; what's the job title; what type of radioactive material; what plant; what type of radioactive materials; that should have been captured in the interview, so if it

wasn't, then, you know, maybe we need to revisit that.

MS. BROCK: And I can send that in.

DR. NETON: Oh, sure. Absolutely. Or we could arrange for another follow-up interview if you have additional information to add.

MS. BROCK: And, let's see, that brings me to my -- to my second one, would actually be the issue of dose reconstruction. I have a letter with me to one of the claimants from the Department of Labor stating that dose reconstruction could take months, even years. And I'm assuming that's accurate, and I just would like to say that that is very disheartening because these claimants do not have months or years; they are dying daily. Even though I do understand there's a process that one must go through, and especially after being here today, you know, I can see that NIOSH is actually making great efforts in this. And I can empathize with all sides, but when it's obvious that workers were endangered, and they were, that's a given, and when you know that they were exposed to some of the most hazardous materials known to mankind -- and I'd like to make reference to an exit interview of Merril Eisenbud conducted January 26, 1995, by

Thomas J. Fischer and where Mr. Eisenbud states that Mallinckrodt was to be -- is one of the two most worst facilities. And I also had a concern about, if like in my father's case, if the Department of Energy, it's my understanding, could not find specific things in reference to my father, then when you dose reconstruct that, I'm assuming you use coworker data. And that kind of gives me grave concerns because, as I said, he had numerous job titles, and I'm wondering at that point if that's possible to even -- even do that if they worked seven days a week, 14-hour shifts, and maybe he was in, you know, different areas, is that possible to even do that. And then I wonder when does dose reconstruction not become feasible because my ultimate goal would be -- again, I think I've talked to several people -- to make Mallinckrodt a special exposure cohort, so I mean is there --

DR. NETON: The use of coworker data may not be possible. Clearly, if we can't identify coworkers for your father in the facility, and then we would go back one level, which is in our Rule, and revert to the exposure models essentially, which we would try to generate from the type of materials that were there, and their concentration data we may

have, that sort of thing. Once we develop an exposure model of that type, if the claimant, in this case it might be your father, could be placed in the environs of what that exposure model covers, and that would be the basis for his dose reconstruction. We're working on approaches like that at other facilities, you know, I can't fill in much more detail on that other than sometimes coworker data may not be possible. And if we don't the source term at all, you're right, at some point we would say it can't be done. We haven't done that yet, but it is a distinct possibility and it's provided for in our regulations.

MS. BROCK: So then is it possible then like after a phone interview like my mother had, if perhaps you can't find all of that, and you can't -- is it possible to dose reconstruct without that Mallinckrodt model? I mean is that possible, or is it something she's going to have to wait for?

DR. NETON: That sort of gets to the issue of how long it takes to do a dose reconstruction. And we need to get sufficient information, obtain sufficient information to develop some type of a model. Once we do that, then we have to make the decision is the model sufficient to -- to calculate

doses for people in the areas in plants that maybe your father had been, so we'll just have to wait and see. I guess I can't fill in any more details on that. I apologize, but I can't give you any more specifics at this time.

MS. BROCK: My last issue is really a policy issue. And if I might use a hypothetical -- and bear with me. Say you have -- and I know we've addressed this -- or you've addressed this with the smoking. If you have two workers with the same exposure, and I don't know, maybe say 60 rem or whatever would be compensable, both have lung cancer, and one is a smoker and one is a nonsmoker, how is it equitable to have that smoker at an automatic disadvantage if they're exposed to the same thing, same amount of time, and they both have lung cancer?

DR. ZIEMER: Russ Henshaw is going to volunteer to answer that.

DR. NETON: No, I don't want to take a shot at this.

MR. HENSHAW: Well, that's a question that does come up from time to time, and I'm not sure how best to explain the theory behind that in IREP. This may be -- somebody please yank me away if I get

too wordy here. But just to go back to the beginning, we have the Japanese cohort that the base-line rates are taken from and the excess relative risk of smoking for lung cancer. That Japanese cohort consisted of, on average, moderate smokers. So now we have a cohort of people for whom our excess relative risk for lung cancer is based on of moderate smokers, and we have claimants who -- some who were smokers and some who were nonsmokers -- some were smokers and some were not smokers. The probability of causation -- and further we're mandated by the legislation to calculate the probability of causation that a worker's cancer was caused by his or her radiation exposure, so now you have the case of two individuals with similar exposures; one's a smoker, one's a nonsmoker. And the hypothetical scenario you present is where under those circumstances one is compensated and one is not, even though they were exposed to the same amount. Well, this gets back to the way the legislation reads, is: Was the worker's cancer as likely as not caused by radiation exposure? And what probability of causation does is calculate the contribution in a probabilistic (sic) way. The contribution of the radiation exposure to the

cancer, the likelihood that that radiation exposure in and of itself caused the cancer. Well, with the nonsmoker there is not -- the smoking is not contributing to that effect, which is -- which is lung cancer; therefore, the probability of causation is higher. For a smoker, we have two contributing factors; one the radiation exposure, one the smoking. So in that case the -- the estimated contribution of the radiation exposure is less. Now getting back to that Japanese cohort -- this probably is making things a lot more confusing, so. But getting back to the Japanese cohort, that was a cohort of moderate smokers, so when we adjust for smoking in our lung cancer model, it does two things: It has the effect of decreasing the probability of causation for smokers, and that varies with the category of smoking, but it also has the effect of increasing the probability of causation result for nonsmokers. So now you plug these two hypothetical claimants into the IREP software; on the one hand you have a factor that increases the probability of causation, on the other hand you have a factor that decreases the probability of causation. So in a nutshell, that's how one person could be compensated and the other

one not. Now the issue you're raising is how is it equitable, how is that fair. I think -- I mean I think that sort of goes beyond the science issue and into an issue of policy, but as of right now we're, you know, we're using the science as best we can for the IREP modeling, and it just so happens that there's probably no more substantiated cause of cancer than smoking, that smoking is a cause of lung cancer. So the data is, you know, unequivocal and indisputable about that, and that's why we adjust for it in the IREP model -- you know, at some point, you know, that might change as, you know, that adjustment may change, we may, you know, tinker with the categories if science or new data suggest that, or there could be some other influences that could cause a policy change, but for right now that's --

MS. BROCK: I know you said it's legislated or mandated through legislation. Is it mandated or is it just to be considered? Is it mandated?

MR. HENSHAW: It's not mandated that we -- that we adjust for -- we adjust lung cancer claims for smoking. I'm sorry if I --

MS. BROCK: Maybe I misunderstood.

MR. HENSHAW: Yeah, it's mandated that we use -- we use the best science available to estimate

most accurately the probability of causation for any cancer model. And for lung cancer, you know, tobacco smoking is the greatest cause of lung cancer, I don't think anybody would seriously dispute that. I mean I understand the issue you raise, I'm not trying to discount that at all, no one here would. I think it's, I guess, an anomaly of the adjustment, if you will, but I don't know.

MS. BROCK: Well, thank you. And the only other thing -- can you hear me -- the only other thing that I'd like to add is just a request to have the next meeting, or the special exposure cohort meeting in St. Louis. It would just be really helpful for the claimants there to see what I've seen today. I mean I just think it would make a big difference. I'm telling you, it's impressed me and I'd like to say thank you.

DR. ZIEMER: Thank you, very much. Let me ask the Board if anyone has any questions for Ms. Brock?

DR. MELIUS: Just in a quick follow-up, I think. The issues you raised I think were very good, and certainly two of them, the smoking issue is one that the Board voted on today to put under further review and scrutiny, and I think we'll be

dealing with that in later meetings. Secondly, the issue of what happens when there's not adequate dose information will be dealt with through the special exposure cohort regulations, and the Board was not pleased with the first edition of those, and particularly in this issue of when is there not adequate information available, so hopefully that issue will get addressed also. Hopefully when NIOSH gets these next set of regulations out for review.

MS. BROCK: Thank you.

DR. ZIEMER: Well, the next one appears to be Richard Miller, whose handwriting -- Richard, did you sign up?

MR. MILLER: Yes, I did.

DR. ZIEMER: Okay. Then, you're on.

MR. MILLER: Good afternoon, and welcome to Charleston. I keep seeing you in these hotel rooms. The hotel rooms, with the exception of New Mexico, all look alike. And as Camille said, I wish we were having it at Aiken, so we would have lots of Savannah River workers here. Otherwise, the hotels are kind of boring, you know, we could just do these in Cincinnati, right, Larry?

MR. ELLIOTT: That's right.

MR. MILLER: But I had a couple of series of

questions for the Board, and the first has to do with sort of leading, I guess, to what happens to the product that the Board generates after it does its review, your audit, or whatever you want to call this. The review contractor shows up and you all develop whatever product it is, your checklist, your evaluation, your audit of your auditor, or whatever the appropriate line is that you're drawing, and then let's just take a hypothetical -- Larry's sort of reading my mind. Do you want to ask this question, Larry?

And -- and -- and the -- and the question would be: Let's just say for example, you all look at a case and you find either unsupported assumptions, questionable assumptions, you didn't look at the, you know, your assumptions on particle size are all wrong, and therefore your committed dose is wrong, and therefore, not only does that affect an individual's case, but it might affect a clache of cases that go back. Say you've handled a site profile, and so you've got a whole of clache of those. When NIOSH gets that, you have a set choice points, I guess. One is you can decode the Blind cases that was brought to the Board, which wouldn't know who it was, but you would -- you would probably

have a way to decode it, presumably. And I guess then the question is: Would you have, either yourselves, or ORAU rework it? I guess that's question one, and question two behind it is: Or would you simply say look, we're not going to do it, this is an adjudicated claim, the case is closed, noted; we're moving on with life, we've got 10,500 piled up and more are like airplanes on the runway waiting to come in, and just say we're going to rework our procedures going forward. And then third sort of choice, perhaps, is you have to go back and review all of those in that clache, which would be a function -- and then how would you know whether to even accept the advice. In other words, you could say professionally, you know, with all due respect Advisory Board, fly a kite. So that's the question.

DR. NETON: I'd like to just address maybe one portion of this, and then leave the policy decisions about what we do up to Larry.

But I think one thing I would like to point out with your question is that we expect that there are going to be differences in dose reconstructions. I mean we have a unique process, we apply it as efficiency process, and we take it only as far as we

need to so that Labor can make a decision. So in your example of particle size for instance, if the contractor, the oversight contractor, the task order contractor that the Board hires comes back with a dose reconstruction that differs by a factor of two because they chose different particle size, but that factor of two might make a difference between one percent and two percent probability of causation, I don't view that as a substantive issue. The issue to the oversight contractor is: Did NIOSH, in my mind, make the correct -- draw the bar on the right side of the line for Labor to make the final decision? So we need to remember that when we're looking at these things. This is not -- these are not exact, accurate dose reconstructions. And I'll stop at that and then Larry maybe address what we're going to do with it if there are substantive issue where maybe a person should have been compensated.

MR. ELLIOTT: I love Richard's three-part, four-part questions, you know, he always fires those and then, you know, expects me to remember each and every significant nuance of -- of what question, which order, but let me just start.

The Department of Labor's regulations, and our regulations both have a clause which allows us

to revisit dose reconstructions that have been completed. That's the clause for DOL or us that we would use to reexamine a dose reconstruction that may have been found to be inadequate or of poor quality. Okay.

Now whether or not -- I think the second question Jim answered, perhaps. The third question is: Would we just take it and would we ignore it? And certainly, you know, the -- the Department's position is this Advisory Board advises the Secretary, and by that fact, gives us advice too on how we do our work. We're going to consider that duly, and depending upon what it is, you know, I can't predict how we're going to go, but --

MR. MILLER: Well, let me give you the hypothetical with the word "material" associated with it, so that we're dealing with a material issue. I'm not dealing with a question of trivia here, so that at the end of the day let's assume that you got the solubility wrong, so that you really have a question of whether it's compensable or not, even though it's not your job or your contractor's job to be sitting around running IREP all day on the dose models as they flow through. Right? At least that's what you tell us. But --

but if that's true, and let's just say you got the solubility wrong for whatever reason, and that's a hypothetical, or a series of factors; the energy level of the neutrons, just got it wrong for whatever reason. That set of assumptions or uncertainties are so wide that you, at the end of the day, if you got a case and you get it back and it was material, would you decode that case, decode the Blind case and rework it and send it back through because the claimant would never know that there case was being audited cause they're blind as well, unless they're getting a phone call under that disputed procedure.

MR. ELLIOTT: Well, the answer to your question is yes, of course.

MR. MILLER: Okay. I didn't know that.

MR. ELLIOTT: Of course, we --

MR. MILLER: I didn't hear that.

MR. ELLIOTT: -- would. We're going to -- I -- I don't see any way out of it. We're going to have to help the Board identify what cases are available, and we're going to have to be the ones to help redact the information as provided in whatever form or shape this actually takes, so we're going to know who's behind each case. We're going to also be

able to track other cases that have the same similarity, the same issue, and they get revisited back through the clause that says rework a dose reconstruction.

DR. NETON: I would like to just add a proviso though, that we -- we would reserve the right to evaluate those comments and respond to them if we don't believe that they are correct. Merely because a person states that the material could have been fast solubility class may or may not be true, I mean we need to evaluate that, and that would sort of be more claimant friendly for, you know, kidney or something like that; so, you know, we would look at it and if there was credible evidence provided by the review that we screwed up, of course we would address that and fix it.

MR. MILLER: I just -- I hadn't heard that before. The authorities I knew existed, but I hadn't heard you actually state on the record that -- that when these Blind cases got brought to you and you could go do that. That's great. That's terrific. That's very -- that's a good answer.

MR. ELLIOTT: Hey, Richard, you could talk a little bit more about the good things we're doing, you know, get some of that on the public record too

-- you know, when you force me to make comment on the public record I'm going to give you an honest response, but I'd appreciate hearing some things from you about some of the good things we're doing, some of the claimant favorable things we're doing.

MR. MILLER: As soon as we move pass the initial Chapter 14, I can't wait.

The -- the -- this is a, to the DOL question. There were a number of policy issues that got raised today regarding whether DOL, or NIOSH, or perhaps even other choices are available as a contracting authority. And I just sort of wanted to float a couple of ideas on that area. I think one of the concerns that was playing out, at least as I sensed at the last Board meeting, was -- the question of whether the Board was really comfortable having NIOSH select, and other others have said it, whether NIOSH should be selecting the audit contractor for you all, so then there was a discussion about how many Board members would participate, who else -- how you would select the auditor so it wasn't seen as NIOSH auditing itself, in effect, and -- and -- or at least selecting its auditor. And then it seemed to me that was sort of one point of clearance, which, if it's resolved -- I

don't know if it is or not -- but if it's resolved, then it seems to me the question is: What are the conflict issues that are raised by having it in OCAS; what are the conflict issues that are raised by having it, perhaps elsewhere in NIOSH, meaning the contracting authority; or in CDC, or jumping completely out of the agency, and in this case, into DOL, and what are the advantages? And a couple of things, at least, come to mind. I guess -- and it has to do with how will it work in the real world if you took it outside of either the NIOSH or CDC world. One of the questions is: If you've got it -- if you've got DOL as your contracting entity -- this is what I was having a hard time getting my head around today -- if DOL is the contracting entity and they say, "Say, we really want to do these telephone interviews that NIOSH doesn't want to do." Okay. It's an issue of disagreement about the scope. How does -- how does that get resolved? I mean cause it's an agency now that has the contracting, and it gets the appropriations too, so they get the money first, and they also have -- they're supposedly going to respond to what the Board wants, although it's not clear what the legal authority is that the Board has to drive what DOL

does. That's not in a statute, so you'd have to create some legal authority. But assuming that legal authority existed, for the sake of this hypothetical question, you know, how -- how would those issues be resolved, which leads to another sort of real-world question, which is -- and I don't even know what the boundaries are that you've all thought about is -- would the auditor have access only to you and your records, this audit contractor, or would they also have access to your contractor, meaning ORAU -- you know, and -- and -- and depending on what your answer is, or depending on the terms and conditions of that, you all may find yourself, you know, in this interesting situation where, you know, you're going to have to start resolving these interagency disagreements about how to work this through. And so I just -- I wanted to see some sort of real-world examples about how this is going to -- is this really going to work smoothly, I guess is the question.

DR. ZIEMER: Richard, I don't think any of us have a good answer for you. We were raising those kinds of questions in different forms as we debated this -- this very issue. We indicated earlier today that while there may be some pros of

using DOL, there are also some cons, and vice-versa. I'm not sure the hypothetical things that you raise here now are even answerable at this point to any of us, unless Larry has prepared the answer, but -- but I'm going to take those more as rhetorical questions. I --

MR. MILLER: Yeah.

DR. ZIEMER: You're raising issues that we can think about as we --

MR. MILLER: I'm raising those questions to think about it would operationalize. (sic) And I guess to lead to a second part, which is how long is it going to take us to -- you all, NIOSH staff, whomever, makes the decision or advice, how long is it going to take you to figure this out? In other words, do you have to go to your next Advisory Board meeting in Knoxville, St. Louis, wherever, before you decide who is even going to be the contracting entity before you put the RFP on the street because there's a lot -- the devils may be in the details here, I don't know.

DR. ZIEMER: Well, come back tomorrow and find out.

MR. MILLER: Oh, you think you're going to decide tomorrow?

DR. ZIEMER: I would hope -- I would hope we can make a decision by tomorrow, but in any event --

MR. MILLER: Yeah.

DR. ZIEMER: -- you know, I clearly -- and let me just say that I'd be a little nervous about -- we have a certain mandate under law and under the Executive Memorandum in terms of the responsibility of this Board and how it's set forth and so on. And it's not clear to me at all that we could even, as I said, legally move this procurement to another agency, at least the way things are set up now.

MR. ELLIOTT: Let me talk to that because that -- we don't believe there's any legal authority issues here. It's one procurement, whether it's run through a -- a HHS Procurement Office, or it's run through a DOL Procurement Office. The Board advises the Secretary of HHS. Whether it's NIOSH effecting and awarding and administering the procurement, or it's DOL, any issues that come up through the deliberation of the Board in development of task orders is going to be transparent to the public. The Board will report to the Secretary if they've got problems with whoever is effecting, you know, the -- the issue at hand for that given point. I don't know what to say beyond that, I mean that's --

DR. ZIEMER: That answers your question then on what the Department of Labor could impose or not impose on the Board.

MR. MILLER: Well, you'd have to formalize that, right, in some respect, wouldn't you?

MR. ELLIOTT: The Department of Labor is not -- not -- all they would be doing is taking on the administration of the contract. There's no -- there's no necessity to have a legal authority or formality about that.

MR. MILLER: Except that Dan takes direction from this Board. Wouldn't they, I mean wouldn't you all, if you come up with a task order and say do this.

MR. ELLIOTT: They -- they're just administering the procurement, the contract. That's all they're doing. They don't -- you know, if the Board comes up with a task order, the -- the only bounds that would be on this would be the same for DOL or NIOSH, and that's to stay within the FAR, Federal Acquisitions Regulation. Okay. So if a task order comes surfacing up through the Board that steps out of bounds in that regard, then whoever administers it in the government is going to say whoa, you can't do that.

MR. MILLER: So if -- so I guess then the question is: If the DOL is merely carrying out what sounds to me to be a kind of a pure administrative function, not quite administerial because it's probably more deliverable than that, but not a whole lot more, than an administerial function, what's the big upside in terms of -- I mean what is the upside of -- of -- of moving the DOL versus using either some part of NIOSH or -- I mean I -- I -- I could see where you don't want to have the people who are -- who are administering dose -- who are overseeing dose reconstruction also overseeing their own audit. I mean there's something intuitively reasonable about that, but I mean you -- you can get -- get around that pretty quickly, you know, just by how you, you know, use your administrative boxes within CDC. And -- and the only reason I'm posing it is just because every time we look at another set of interagency relationships, and I'm not talking about the really tedious ones that you have to deal with, but -- and -- and -- and -- and -- and -- and for which we think you're doing a good job. Noted. But what is the upside? I mean what is the real upside because at the end of the day the Labor Department has a set of interests in this thing.

MR. ELLIOTT: Sure. Sure.

MR. MILLER: They are not completely neutral. They need to go to court someday and defend when somebody comes along that says we contest; we don't like the way you did dose reconstruction; we challenge your assumptions, or we don't even like ICRP, you know, we want you to use some other model, whatever it happens to be they want to go to court over; at the end of the day, right, they go roaring into court and DOL is going to have something to hold up and say geez, you know, this thing's been audited. Look at these smart people on this Advisory Board, and look at this smart auditor they brought in, and look at these smart audit reports, and this thing is not hand leading, this is like the real, you know, this is the Real McCoy, so they need this audit function, but do they need this audit function in such a way that it's going to -- that it's their contracted authority versus yours?

MR. ELLIOTT: I don't know if you were in the room earlier when Pete Turcic and I were talking to this point. The only advantage that it brings to NIOSH/CDC/HHS is it removes this perceived conflict to DOL, if DOL administers the contract. We -- you

know, the only -- the only aspect of the relationship if DOL run it that we talked about earlier, Pete mentioned that we would probably need a Memorandum of Understanding. Our relationship with DOL has been exceptionally good over the course of this -- this program's history, unlike that with another agency that we've had. So, you know, we've -- we've even talked about, you know, how quickly an MOU could be put in place and all the principals in both sides, both departments are -- are knowledgeable of this and ready to that if that's what it takes, so.

MR. MILLER: Okay. All right. I mean I just -- it -- it sort of popped up. This is the first time it was sort of discussed probably, and, you know, at least from my perspective I just sort of thought, you know, if you want to move it out, you know, you can move it to another part of NIOSH, I mean you don't have to move it all the way over to DOL, you can move it over to another part of CDC. I mean, you know, I wasn't quite sure the rationale for that versus, or, you know --

MR. ELLIOTT: Let me be clear.

MR. MILLER: -- OCAS and put it in --

MR. ELLIOTT: NIOSH is NIOSH. Okay. I am

NIOSH. I report -- I report to the Director of NIOSH, so it's not OCAS. When we do a procurement, it's done through NIOSH's Procurement Office.

MS. DiMUZIO: It's done by the CDC.

MR. MILLER: Right.

MR. ELLIOTT: Which is CDC's.

MR. MILLER: Right. That's the point, the CDC.

MR. ELLIOTT: So -- so if it's CDC's, it's CDC's. It's all -- it's all in the semantics. If you want to call it NIOSH; you want to call it OCAS; you want to call it CDC --

MR. MILLER: Okay.

MR. ELLIOTT: -- we're all in the same boat.

MR. MILLER: Okay. All right. Thank you.

DR. ZIEMER: That concludes our session for today. I'd like to ask, Cori, are there any housekeeping informational items we need to pass along this evening? I'm not aware of any.

MS. HOMER: I would suggest that if you have anything requiring security, please remove it from the room.

DR. ZIEMER: Okay.

MS. HOMER: Laptops, any kind of equipment.

DR. ZIEMER: Okay.

MS. HOMER: Because I can't guarantee that the room will be locked.

DR. ZIEMER: Okay. Thank you. So noted.

We begin tomorrow morning at 8:00 a.m. with the sort of casual half-hour, and the Board is recessed.

(Whereupon, the above-entitled proceedings were recessed at 5:05 o'clock p.m., to be reconvened Thursday, February 6, 2003, at 8:00 o'clock a.m.)

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C E R T I F I C A T E

STATE OF GEORGIA)

COUNTY OF FORSYTH)

I, Debbie G. Williams, Certified Court Reporter in and for the State of Georgia, do hereby certify that the foregoing proceedings were taken down by me; that the foregoing proceedings were reduced to print by me; that the foregoing VOLUME I, consisting of pages 1 through 262 represent a true, correct and complete transcript of the proceedings; that I am not a relative, employee, attorney or counsel of any of the parties; that I am not a relative or employee of attorney or counsel for any of said parties; nor am I financially interested in the outcome of the action.

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This, the 22nd day of February, 2003.

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DEBBIE G. WILLIAMS
CERTIFIED COURT REPORTER, B-2167

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convenes the

ADVISORY BOARD ON

RADIATION AND WORKER HEALTH

VOLUME II

The transcript of the Meeting of the Advisory Board on Radiation and Worker Health before Debbie G. Williams, Certified Court Reporter and Notary Public; commencing at 8:30 a.m., Thursday, February 6, 2003, at The DoubleTree Guest Suites, 181 Church Street, Charleston, South Carolina.

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I N D E X

VOLUME II
February 6, 2003

P R O C E E D I N G S

8:30 a.m.

DR. ZIEMER: Good morning, everyone. We want to also welcome Henry Anderson to our group this morning. We're glad to have you here, Henry. We got all the good stuff done yesterday.

DR. ANDERSON: Yeah, that's what I figured.

DR. ZIEMER: We'll tell you about your assignments a little later.

I want to remind all of the Board members and others who are here today to register today, even if you registered yesterday, we ask you to register each day, so please do that in the registration book if you haven't already.

Also, the members of the public who wish to comment during the Public Comment Period, we ask you to sign up for that. I do want to give members of the public a kind of heads-up that it's quite possible that we will complete our work schedule earlier than the original Agenda shows, in which case we would move the Public Comment Period up a little bit toward closer to midday, so if you will make note of that. I don't have a specific time at this point because it's going to depend on how hard and long I'm able to keep the Board working.

We're going to begin this morning with the Minutes of the last Open Meeting, that is the Meeting Number 10. That meeting was the January 7th and 8th meeting. I'd ask the Board members to get their copies of that, and what we will do on the Minutes, I ask you that if you have typos and minor grammatical changes, that you simply pass those along to Cori separately. As we approve the Minutes we want to take action on specific things that may be conceptually or factually wrong, so when I ask for corrections, or additions, or deletions, we'll focus on those kinds of things. So let's -- let me call attention first to the Executive Summary section of the Minutes. I might say parenthetically, I had an initial review myself of these Minutes and I shortened the Executive Summary by several pages. It was nearly as long as the Meeting Minutes, and it still seems a little long to me, but because there were a number of bullet points that I ended up leaving in that I was going to delete. I was planning to delete nearly all of the bullet points and just let it stand, but I decided, for example, to leave the Public Comment Summary, all of those bullet points in, rather than simply say we had a Public Comment Period, so the Executive

Summary is a little longer than perhaps it should be, but nonetheless, that's it.

Let me ask if anyone has any corrections, additions, or deletions for the Executive Summary? It's pages 1, slash, 8 to 8, slash, 8.

MR. NAMON: Dr. Ziemer, on page seven --

DR. ZIEMER: You need to identify for the court reporter.

MR. NAMON: Yes, David Namon, Department of Health and Human Services.

On page 7 under Board Housekeeping, the description of the possible need for a conference call on February 19th and 20th is not accurate, and not the way it was actually said at the meeting, and I would suggest that we delete everything after the -- where it says February 19 or 20 to the end of that sentence.

DR. ZIEMER: "The likely need for a conference call on February 19 or 20, for two to three hours to discuss SEC rulemaking to be issued on" -- I'm sorry. What are you -- what are you saying?

MR. NAMON: I'm saying that -- that everything after the word "rulemaking" is -- is not accurate, and is not what was said at the meeting.

And so, obviously the rulemaking was not -- there was not a rulemaking issued on January 20th. That's also not what was said at the meeting that there would be, so I would suggest that we would remove everything in that phrase.

DR. ZIEMER: Okay. Let me make two comments first. The fact that it didn't occur is immaterial to the minutes.

MR. NAMON: Agreed.

DR. ZIEMER: So it's what was stated at the meeting which you said was incorrect?

MR. NAMON: Right.

DR. ZIEMER: What was stated then? Because this is based on what the recorder recorded.

MR. NAMON: What stated at the meeting was that it was possible that something could be issued during that time frame, I think during the month of January.

I think the clearest way to deal with it would be to delete everything after the word "rulemaking", if -- or to delete everything after the number 20; but in any event, it was not -- obviously nobody said, including you, Mr. Chairman, nobody said that there would be something issued on a particular date.

DR. ZIEMER: Oh, as opposed to an expected.

DR. MELIUS: I think what --

DR. ZIEMER: It was the expectation that somebody -- something would be issued on or about that date.

DR. MELIUS: Well, if it were issued on that, that was maybe the -- the week it might be issued, in which case, then we needed to be able to have our conference call within the 30-day period that we needed it to complete the Board's review, so the date came from an estimate of -- I'm trying to figure out what was the correct timing for those conference calls. And the particular dates were discussed. I mean it is there, but I think what's not accurate is the -- I don't think, Larry, or whoever was speaking at that time said that it would be issued on the 20th.

DR. ZIEMER: I have a -- Tony, you have a possible solution. I think -- I think we want to capture the idea of why we were going to have this meeting, and it was based on an expectation; the fact that it didn't occur is not a part of the minutes, but we do want to correctly express what did occur at the meeting.

DR. ANDRADE: Thank you. I do recall that

the SEC rulemaking was, in fact, discussed, and we talked about the possibility of the SEC Rule to be issued on or about a date, so I would propose that the solution is to simply include the word possibly between "to" and "be" on that particular sentence. In other words, two to three hours to discuss the SEC rulemaking --

DR. ZIEMER: How about an expected SEC rulemaking?

DR. ANDRADE: Okay. Discuss the expected SEC rulemaking, possibly to be issued on January 20th.

But I do recall that that was the essence of our conversation.

DR. ZIEMER: Well, the expectation was that we would be discussing the rulemaking at this meeting and then finalize it.

DR. ANDRADE: Right.

DR. ZIEMER: Yes, go ahead.

MR. NAMON: I have the transcript in front of me, and it was indicated that we were hoping that something would be published during that week of the 20th, but again, no one suggested that a particular date that it was expected.

DR. ZIEMER: Based on that, let me suggest:

The expected SEC rulemaking that -- that possibly would be published the week of January 20.

MS. ROESSLER: Or "if it is in January."

DR. ZIEMER: An expected SEC rulemaking if it is issued the week of January 20.

MS. ROESSLER: Uh-huh (affirmative).

DR. ZIEMER: Would that solve it?

DR. MELIUS: Yeah.

DR. ZIEMER: We're not trying to --

DR. MELIUS: That's fine.

DR. ZIEMER: To discuss the expected SEC rulemaking if it is issued on the week of January 20th.

So that would capture what we did based on some expectations without pinning down a date. Does that fix it, I suppose. There's no question we discussed it while we were doing the meetings. We're not trying to pin down NIOSH as having committed to that.

MR. ELLIOTT: I'm even more gun shy to say anything.

MR. NAMON: Now, when you get to the main minutes there's a similar change necessary.

DR. ZIEMER: Oh, yeah. Hold on for that.

Okay. Anything else on the Executive

Summary? Wanda.

MS. MUNN: I haven't seen the transcript, but my memory of the meeting dates that we discussed -- actually, what I wrote on my calendar was that April 28th, 29th, was a potential, and we still, that May 1st and 2nd were the probables. I -- I don't know whether that's -- whether my notes are incorrect. Of course, we're not going to get around to discussing that until this afternoon, but I had potential April 28th, 29th, and probable on May 1, 2.

DR. ZIEMER: Anyone else comment? I have both blocked off without any change.

MR. DeHART: I believe that was for the forthcoming meeting, the next meeting, not to be a phone call.

DR. ZIEMER: Right. Right.

MS. MUNN: Yes, that's correct, but I'm talking about the next meeting.

DR. ZIEMER: She's asking whether -- whether we indicated a preference of one over the other.

MR. DeHART: The 28th and 29th I'm not available.

MR. PRESLEY: My recollection on that was that we marked them both, and Cori was supposed to

go back and see which one she was able to get a date on.

DR. ZIEMER: Apparently, all of these were indicated as being available to members of the Board. I don't believe this says one or the other is preferred at this point.

MS. MUNN: Okay. My notes may be wrong.

DR. ZIEMER: Okay. Thank you. Any other corrections or additions on the Executive Summary?

Now, let's go to the main Minutes, and we can handle the same change that we just noted on Board Housekeeping.

David, what page are we looking at that?

MR. NAMON: It's page 21. It's the second paragraph under Board Housekeeping. I think if you changed the word "will" to "may".

DR. ZIEMER: Yes. So, "will be" to "may be issued", a conference call may be needed. That will solve that. Thank you. Without an objection, we'll make that change.

Other comments, other corrections, or additions?

There's no additional corrections or additions. The Chair will accept a Motion to Approve the Executive Summary and the Minutes as

noted with the changes.

MR. PRESLEY: So moved.

DR. ZIEMER: Seconded?

MR. DeHART: Second.

DR. ZIEMER: Further discussion?

All in favor, aye.

(Ayes respond.)

DR. ZIEMER: Any opposed, no.

(No responses.)

DR. ZIEMER: Abstentions?

(No responses.)

DR. ZIEMER: The Motion carries, the Minutes then are approved with those changes as made.

Now, let me give you kind of an outline of where I see us headed on our Work Session here. There's several items that we need to address. One of those will be the decision as to who will be the -- let me just say the agency that will let the contract on behalf of the Board. And we currently have two options that we're considering; one is the Department of Labor, the other is NIOSH or CDC; we view that as one entity, NIOSH/CDC. We don't have to decide that at the front end here, but I would like us to come to closure on that if possible today, so that we can proceed and have whatever time

we gain by moving forward achieved. So that decision is before us.

We also need to come to some sort of agreement on exactly what will be covered in procedures for the review process; that is, the review of completed dose reconstructions, the audit process, if you will.

Now, I'm going to propose certain things here as we proceed. Number one, I have some overheads or slides where I hope I've captured what we kind of delineated yesterday. This will help us and maybe also help the recorders to figure out what it was we agreed to.

I also have a kind of a strawman procedure to give us some feel for what a procedure might look like. But in preparing the strawman -- this is just something for us to shoot at -- in preparing this, it became pretty clear to me that to really do the procedures, I don't think we can sit here in Board session and develop that; in fact, it seems to me that we are going to have to do a mockup; we're going to have a workgroup maybe go to NIOSH and actually go through some dummy reviews -- dummy reviews might not be a good word for it, but reviews for dummies, maybe that's what it is -- maybe one or

two of each kind and start stepping through it and say okay, what do we do first. We look at the site profile; is it complete, and start -- sit there and really work through the procedures. We may also need to take a look at some of NIOSH's and ORAU's procedures to see how they're going about looking at these things. I mean step wise because we can't -- I don't think we can proceed beyond that today, but -- but we can at least identify what the complements of those procedures are with these, so that's what I propose we do today, and make sure we're all on the same page in terms of sort of the overall scheme of things; what needs to be covered, maybe what does -- what do the final products look like, and what would be the content, what procedures we need to cover. But I'm not sure we can go beyond that today, and we may need a workgroup then to follow up on it.

Okay. So we have those two things relating to the completed dose reconstruction review process.

We also have the issue of the special exposure approval legislation, which we know will not be available January 20th, or even the week of January 20th, but may -- but may be published sometime in the near future.

Now, our next meeting, if it's the end of

April or in to May is nearly three months away; all of February, all of March, most of April, and if that hits the street before April 1st, then our next meeting will be too late to react to that proposed rulemaking. So I think we will probably need to identify another meeting time before then. So when we get to the Board work schedule later this morning, that will be one of the items we'll need to address. And there is some possibility we may have something close to an estimate of when that might --

MR. ELLIOTT: We're hoping to hear something this morning so that we can inform the Board to help make the schedule happen.

DR. MELIUS: 2003. Pin it down. We've got to pin it down.

DR. ZIEMER: In any event, that's what we have before us, I think, today. And in thinking about that and perhaps the extent to which we can do some of that work, it occurred to me last night that we might very well finish by midday, depending on how things go.

Now, let me just pause, and if anyone wants to react to anything I said, or comments, or shall we proceed? I'm open to -- always open to better ideas.

Henry, you can't move to dismiss now.

MR. ELLIOTT: Two things I would suggest that you consider and you perhaps want to put these into the future, but this concept of having a task order prepared so that it's on the table so that, I mean when the contract is awarded I don't think you want to have a delay of developing a task order; you want to be able to present that within the first week of the award to get these folks started. The second thing that I think you should consider is something I mentioned to Mark yesterday afternoon, and I think Richard Miller also brought it up in his public comment, is what's -- what's your product at the end of this, you know, what are you going to deliver to the Secretary. I think you need to think a little bit about that and through that. I don't think you're going to want to provide a recommendation on every review that you do, every dose reconstruction review that you do, but I think you need to figure out, you know, what's the appropriate communication to make.

DR. ZIEMER: Right. And in fact, that's the nature of one of the key questions I will ask this morning as we proceed.

Other general comments before we move on?

Okay. Let's see, do I need to work that clicker from the front or can I work it from here?

DR. NETON: We'll have to check and see. I guess so, maybe it will work from there. Why don't you just try it once and see if it will move forward?

DR. ZIEMER: Okay.

So this is what we -- this is what we were discussing yesterday, and what I've done here is broken this into several points that we were talking about. The first was that we said we had to have -- had to identify the available cases to review. This is not necessarily just those completed, but as we look forward, so I've -- all I'm doing here is raising some questions, and I want to make sure in these questions that we've covered content wise what it is we're trying to do. For example, who should do this, is it the full Board, is it a Workgroup, is it a Subcommittee, when should it be done, and what's the nature of the product; that is, whoever identifies these cases, do they come back to the Board with a report and say these are the cases we believe should be reviewed, or do they just proceed? Are these the right questions; are there additional questions; and to what extent can we answer these

right now.

I just would like to capture this if we can and get the Board's ideas, and then we'll move on to the next item, which is the case selection process. Okay. Again, we talked about each of these a little bit yesterday, so I'm feeding back to you what we talked about. We talked about some of these questions yesterday, but I want to make sure we're on the same page on it, so.

Okay. Roy.

MR. DeHART: When we're talking about who should do it, certainly at the initial stage I think the Board as a whole needs to be involved, but that doesn't mean it needs to be the Board going through. A workgroup could come out with suggestions using the model we had on the percentage that we had developed before. So I would suggest that we have a workgroup that would go through the available 60, 70, 80, whatever it happens to be at the time, and make the selections against a matrix, and then present those to the Board for final approval, so the Board would know exactly what the process is.

DR. ZIEMER: Okay. Let's get some other feedback. Jim.

DR. MELIUS: Yeah, I -- I think we need a

workgroup to do this, but I think it's got to be sort of a step-wise process throughout this, and maybe it's more than one workgroup or different workgroups, but as I understand what's required by the FACA regulations is that we -- the Board would have to approve a lot of the steps along the way. So I would see it as a workgroup that would put together, you know, do some of the -- the work, looking as they develop new forms, whatever would be involved, then would come back to the Board probably at each meeting with a certain, you know, things for approval, and is this going to apply to -- some of this would be the task order development because that's really an important part of this process, and I think actually the first thing that we should try to work out, and maybe it's having the workgroup do it, is a schedule for this step wise because we have a number of issues that are going to need some time to work on.

Larry, you've already mentioned the idea that we need to get these task orders ready at the -- hopefully at the time that the -- or around the time that the contract is awarded. We also have this OMB question hanging out there about the -- the interview issue. And so I think the sooner we can

get that prepared, the better in terms of getting approval for that. So I think the only way it can be done is through a workgroup, but a workgroup that serves discrete functions or tasks that would then report back to the Board at each meeting, and then we would go on and then do something else at the next meeting and so forth.

DR. ZIEMER: And keep in mind, we can always change the process at any time, but I've kind of looked at this as the first time through, and, you know, once we've sort of developed the procedures and get -- get the process rolling, we may want to alter how it's done, but I'm really looking at getting under way, and I've heard a couple of suggestions about the workgroup.

Henry?

DR. ANDERSON: Yeah, I think a workgroup, but it would seem to me if -- if this is basically an algorithm, I mean we've said which cases we want to review, then basically it's you pick a cutoff date and then everything before that you then classify them into our various categories, and then you'd have a random, you know, selection process. So it would seem to me if you pick various dates, whatever's, you know, prior to that date would be

eligible, and then, you know, each time we meet perhaps we could have -- or you could set the date of cutoff a certain number of weeks or whatever prior or completed cases, however we're going to do it, prior to the next meeting, so that at the meeting we could say the process was done, and here are 6, 10, 100 cases ready to go, so that it would it be a -- once we decide how it's going to be done it would be -- at least the selection process would be more automatic than having a group necessarily have to get together to review that data, and then say yes, do the selection process. I mean I -- for the early on I think the more we can kind of automate it and it's transparent because we've set out the criteria for how to do it, it then just has to be, you know, so that the records actually are completed and available and all back wherever they need to be for the review to start, and that's kind of a NIOSH, you don't want to set a date so that we'll have some cases come in that aren't yet really fully completed. So that's how I would do it and if -- if it's setting up those, translating our guidelines as we've put together into an algorithm, that certainly could be done by a workgroup, but I would not want to have a workgroup have to meet

every time to say here they are, and then shuffle them into groups. I think if we select the criteria that are already in NIOSH's data base, that can all be done electronically.

DR. ZIEMER: Other comments? Wanda.

MS. MUNN: Yes. I think that Jim and Henry both have captured most of my thinking, which very clearly indicates in my mind that we need two separate workgroups approaching this initial issue; one of them to identify how the NIOSH matrix is going to be able to present the information to us, and identify how we can use that matrix to resolve our issues of percentages in terms of how we're going to cross-cut the reviews that we do; and another to actually put together the kind of checklist that we were talking about to work with NIOSH to see what their checklist covers; is it adequate for our purposes.

DR. ZIEMER: Right. I don't want to get you ahead of the headlights here. Those are separate issues. Right now it's the issue of saying what's out there. NIOSH will have completed a certain number of cases. And we talked about some extremes, suppose they were all Savannah River cases, then what do we do.

MS. MUNN: Yeah.

DR. ZIEMER: Or do we say okay, we're going to sample a certain amount of those and then wait for a certain number of these. So this process, the identification of available cases, is kind of looking ahead at -- at what NIOSH is doing and saying what parts of these are we going to look at.

DR. ANDERSON: Yeah.

DR. ZIEMER: That's all it is, and so we'll say who's going to do that; how soon do we do that; do we have to do that right away, like within the next month, or can we wait till, you know, after the contract is let. I'm trying to pin this down because a lot of what we've done so for is fuzzy. We're going to do this, but who is going to do it, and when are they going to do it, and what is it they are going to do. That's sort of what we're asking here. And that's what I would like to get the Board -- and I don't know the answer to those things; it's hard enough to know the questions to ask, let alone the answers, so there may be some other questions. And then what is this group, are they going to come back to the Board and say okay, we have a certain number of cases available from here, here, and here, we're going to -- or what.

So Wanda, and then Tony.

MS. MUNN: So what I'm suggesting is that we form a workgroup immediately to go sit down with NIOSH and do essentially three things: Identify what their matrix is going to cover; identify what they have now; and then bring back to this Board a suggestion as to how we will proceed down the line because obviously, it's anticipated that the number of cases are going to ramp up quickly. And since that's the case, then our first -- first set of cases may not really and truly have much to do with what we're going to do long term.

DR. ZIEMER: Okay. Thank you. Tony.

DR. ANDRADE: Wanda articulated a bit of what I was going to suggest. I also believe that we should form a workgroup, a representative workgroup of this body, in other words, representing all view points, that will come up with a draft of selection criteria, a schedule for -- or a draft of number one, selection criteria; number two is a draft set of task orders; and number three is a draft schedule. And I think that working from the products that Mark has put together, the draft schedule may not be all that tough. Who should do it, and if we can appoint a working group, and I

would suggest that we refrain from appointing multiple working groups and that we keep maximum flexibility by allowing, as time goes on, people to rotate in and out such that those folks with time available during a particular period of time can continue to work. When should it be done? I think the first report back on those specific products that I mentioned should be available by the next meeting, so the workgroup should be meeting in between time. And the nature -- I've already mentioned what the products would be here.

DR. ZIEMER: Very good. And we'll -- we'll sort of keep those suggestions on hold until we hear from everybody, and then when we formalize anything, we can. And you weren't making a specific motion, right then?

DR. ANDRADE: (Shakes head negatively.)

DR. ZIEMER: Okay. Mark.

MR. GRIFFON: I actually agree with most of what's been said. Building on what Wanda and Tony said, I guess I, when we talked about this yesterday, and how I formulated this in my head is that really the selection criteria I think should be developed first. And then the -- when we look at the -- and I know I brought this issue up yesterday,

so it's my issue, but when we look at the cases, I think the cases and how they meet -- looking at our selection criteria and looking at what's available, that's going to build our schedule. That's going to help us to build a schedule going forward and that's sort of how I conceptualized this, but I -- I agree also with what Tony said, that the, you know, the selection criteria, the review of the available cases, and building the schedule, along with the task orders, procedures, and some kind of draft format for the final report form should be developed by some sort of working group, and, you know, the structure of that right now I think is up for grabs.

DR. ZIEMER: Other comments? Robert.

MR. PRESLEY: Can we not come up with a simple formula? We're going to do 150 of these a year, is that correct? That comes out to approximately 12 a month. Can we not come up with some type of a simple formula that we can give HHS and say okay, you know, we want 12. Now, where those 12 lie, it may be 12 out of 50, it may be 12 out of 250. We ought to be able to come up with some type of formula that you pick -- this month you pick 1, 6, 8, and 10; next month you pick 30, 40, and 50; and then we do the checking on whether we

want to do a Blind out of those 12, or what we want to do. And if it gets to where that one month all of them are Savannah River, then -- then the next month we tell whoever it is that we -- the next month, you know, we've done Savannah River, we want some different ones.

DR. ZIEMER: Larry.

MR. ELLIOTT: Those of you who were on the workgroup that Mark headed up, I think -- and I think several others may have seen our tracking system, so you know what it's like; you know we can query it. What I want to take exception to here is that I've heard a couple of people comment that give this to HHS, have the matrix, you know, tell, have them select. We're not going to select, okay. I'm going to tell you that right now. You guys are going to have to select. You can come in, we will set you up in front of the screen, you're going to do the tracking, you're going to do the inquiry there, and then you guys need to select.

MR. GRIFFON: Yeah, and I think, Bob, I agree with you. I just -- in that, the example you just gave with the Savannah River, I mean that's my idea of having the selection sought ahead of time so that we know, okay, over the year we expect these

cases to come through at some point. Month by month we start filling in those boxes and we see, okay, we've completed all of our Savannah River requirements, we've got to find cases in these other categories, and we -- and we track it as we go on, so, you know, that's consistent with what I think we've been talking about.

DR. ZIEMER: Tony.

DR. ANDRADE: I just wanted to mention that clearly we can't anticipate any -- any or all of the problems we may have in finding cases that meet our criteria. That's why I wanted to emphasize -- at least at this point in time that's why I wanted to emphasize the word "draft". This working group should come back with a draft of selection criteria; a draft of a procedure on how to go about working with those cases, a draft task order list, and schedule, because as we go along we may dearly want to address one issue or one particular type of cancer, or something like that; however, the cases may just not be available. So I'd say let's give ourselves maximum flexibility, understand that this is going to be a living sort of piece of work, if you will, and that we will only really begin to be able to focus on all of the issues that this Board

is interested in as time goes on when there are several cases available that -- that are of interest to us.

DR. ZIEMER: It appears so far that there is a pretty strong sentiment to having a working group do this task of identification of available cases; that it probably should be done fairly soon; and the answer to the third question will depend on what they find, but they would come back to the Board presumably, at least the product will be some sort of report back to the Board.

Is that all fair so far? I'm not trying to lock us into anything, but we need to keep that coming back in mind.

Let's go on to the next item, which is the Case Selection Process. And here again, these are items that you all identified yesterday: Case Selection Process; what's the process. We've kind of answered some of this already. Who should do it? It already sounds like that's the working group, at least to start with. When should that be done? That's probably locked in with -- or linked in, at least, with the first item, if I am fairly summarizing what's already been said.

I think the third bullet is fairly obvious,

we agree that the Board is going to need to approve whatever is done by the workgroup.

What's the nature of the product here. And I'm not sure what form this ends up taking. It's clear that we're not asking NIOSH to do the selection, but we are asking for availability of the case information. Now, I'm going to ask Larry a question, so I'm going to pause just a minute.

DR. MELIUS: If I may comment. It wasn't clear to me yesterday, and I think we're going to need to get it clarified, this whole issue of the Board having to approve sort of every step. And at least based on my recollection of the discussions yesterday, was there how we do the -- for the Board to do the case selection, you know, I mean can we have a workgroup do that, the actual case selection? Is that -- can we -- I think that it would make more sense if we would approve the procedure for the workgroup --

DR. ZIEMER: I think that was the understanding that we would say that the recommendation might be that we will review a certain number of cases of this type, and this type, and this type, not that it's this person, this person, and this person. And requesting the Board

-- request by the Board to NIOSH/ORAU to provide the case files with certain characteristics, I'm not sure what that means except in -- and I'm not sure that you know what that means yet in terms of the extent to which the identification of the individual claims has to be done. So we would need to work with NIOSH and ORAU on this in terms of privacy issues because in principle we are trying to review this process independent of who the claimant is; obviously, you would know from the site from which the claimant came because we would still want to make sure that we don't have conflicts of interest in the review process. But those issues remain, so I'm not sure what we mean exactly by requesting this of NIOSH. Clearly, we're not going to ask you to pick the cases.

MS. MUNN: No.

DR. ZIEMER: But to make available something, a product that can be reviewed in whatever form. So comments on this.

DR. ANDRADE: Again, to maintain flexibility, we may have selection criteria that might -- that if we're hard and fast on them we may not be able to meet them the first or second time through; therefore, we, the working group can come

up with a selection criteria. It can also come up with the cases, given what NIOSH tells us -- yeah, NIOSH tells us is available, and we can work on one criteria, rather than another.

I envision this working group, again, if we have rotating membership, to provide different products at different periods of time. For example, if we commission a working group today, then I believe that the first product, if you will, will be nothing more than administrative procedures, as Jim alluded to, okay. And those can be reviewed by the Board during our next meeting; however, once the contract is let, then the product, the nature of the product is going to change dramatically. What I would envision is general comments on how well the Associated Universities is doing their job, and also, perhaps findings, if any, on -- or questions that may come up about how they are doing dose reconstruction, whether they might pick out a couple of areas that we might want -- we might be interested in reviewing. So I think that that is the direction in which the type of product will go as time goes on, but we should give the working group -- again, if it is a representative working group, representative of view points across the

Board -- as much flexibility to come up with the cases, the selection criteria, maybe change control processing insofar as changing the -- the criteria, the selection criteria, depending on what is available from NIOSH. So I think -- I think that pretty much sums up the -- the way I feel that we can get our arms around this fuzzy issue.

DR. ZIEMER: Thank you. Jim.

DR. MELIUS: One thing that we talked about yesterday that I think will be important for the workgroup early on is we're going to need to be able to project the number of cases that will be available over time. If we set up selection criteria that are very specific, we may -- we could easily end up with a situation where nothing would be, those kinds of cases wouldn't be available for five years or something, I mean, you know, something sort of like that, and so I think we need to have a feel for what will be the schedule of case -- availability of cases, given the criteria and how that can sort of fit into this process also.

DR. ZIEMER: And clearly we would need to work with NIOSH and ORAU on that.

MR. GRIFFON: Yeah, and Jim, I think that's consistent with what I said. The only thing I

didn't want to see happen is that the availability of cases drive the selection criteria. I think we should, you know, think of that.

DR. MELIUS: Drive the schedule.

MR. GRIFFON: Drive the schedule, right.

DR. ZIEMER: Roy DeHart.

MR. DeHART: What we have really discussed, I think, for the working group was working initially, was a matrix. And a matrix can be filled in at any time, so all you do is whatever you have available that you fill -- put the squares where you need to, and over time you fill them in.

MR. GRIFFON: Well, I think Jim's point is that we don't want the matrix to be empty for the first three years, right?

DR. MELIUS: Yeah.

DR. ZIEMER: Do you want to move on to the next item at this point? And if I could summarize, it appears that this work could be done in conjunction with the other, that is the same workgroup initially address these issues together. Okay.

Henry?

DR. ANDERSON: Yes, since we -- since there's a considerable backlog now of cases that are

in the system I guess the question would be to NIOSH, what is the -- you know, are they going through the cases in numeric order, the first-in, first-out --

MS. MUNN: Yes.

DR. ANDERSON: -- or how they're doing it because it could be that if we set up some criteria, if it isn't first-in, first-out, then they could, in fact, over a year set up their review schedule that would be -- would assure that some of the cases were interested and go through the system. Now, that is innately unfair -- unfair perhaps, but that's what --

DR. ZIEMER: We heard yesterday that some of the --

DR. ANDERSON: First-in, first-out.

DR. ZIEMER: -- first-ins are still waiting, yeah, in the long queue because of unavailability so far of the -- or lack of information.

DR. ANDERSON: Yeah, I understand, but if it's first-in, first-out, then we ought to know -- we ought to know where they're coming, you know, to be able to look at them.

MR. ELLIOTT: We are working first-come, first-served, but that doesn't mean that you reap

the fruit of that in those -- in the sequence.

DR. ANDERSON: Yeah, I understand. Yeah.

MR. ELLIOTT: So, for example, on, you know, Bethlehem Steel site profile may knock out 300 claims for Bethlehem Steel in one fell swoop, but those 300 claims, you know, there's probably a few of them were in the 1,000, and, you know, the next, they just sprinkle across, you know, in sequence.

DR. ANDERSON: Right. Yeah.

MR. ELLIOTT: And so it's very hard for us to predict when a particular claim in sequence is going to come to final closure, so.

DR. MELIUS: And I think there's also a potential problem in that some of the more difficult -- some of the cases for which it's more difficult to find information, to get adequate information, are going to back up in the queue, and wait for a site profile information, and that in some ways could bias the selection process if we, when we pick from the first 1,000 or whatever the number would be, so I think there's some details that really have to be looked into to make sure there's a fair selection of cases.

DR. ZIEMER: Mark.

MR. GRIFFON: Yeah, and that was my point

about -- about not letting the availability of cases drive the selection criteria because I think that, you know, some of those more difficult cases are going to be the ones we're more interested in reviewing also, so.

DR. ZIEMER: A good point.

The third item we talked about was the actual procedure for the selection of -- this is the process, but the actual procedure for the selection of cases. You see I'm asking some of the same questions here. And they start to overlap, obviously, but I've separated them out. I think it appears now, based on the discussion, that some of these answers are rhetoric, again, working group, and we need to get underway with this. Keep in mind that the actual procedure is different from the process. The procedure is -- well, look at the end there: What does a procedure look like? I've asked that question. What does the selection procedure look like? And if -- if we move toward having a workgroup work on these things, then we would charge them with doing that, tell us what -- and come back to the Board and show us. That's not something I think we can do here. In fact -- well, we'll get to it in a moment. Let me solicit any other comments

on this. This is the procedure for selection of cases. It includes like you just mentioned, Mark, what about the difficult cases which are down the road; how do we assure that our procedure is cognizant of those, so that as we instruct in the selection of the cases that we allow for that, how do we take care of this matrix, so.

Any other input on this item? Again, these topics are all ones that were brought up by the Board yesterday. I just want to make sure we're on the same page as we go forward.

We're okay? Okay, let's move on.

Procedures for the review of the cases. This is having done the selection, when we actually get cases to review. We need a review procedure, and this question: Who is going to develop the procedure, when should that be done, does the full Board approve the procedure, and what would that look like?

After asking those questions I thought about this further, and have bounced this idea off a couple of people this morning. It seems to me that to answer this, what would a procedure look like, we need to do one or two, or more, mock -- I call them mock reviews, and actually have maybe it's the same

workgroup sit down with some cases and start through what would look like a, say a Basic Review. Now, the first time through there's no procedures to even do this. And you have to sit there and say okay, what is the first thing we do, you know, do we ask is the site profile adequate, or maybe step one is: Is there a site profile? Is it adequate? So you start looking at procedures, but it seemed to me that we're going to have to have a group hammer this through and develop the procedures. And maybe look at NIOSH procedures as to how they do a review, their own, you know, the dose reconstruction; maybe look at ORAU's, and gain some clues as to what it is that needs to be done if you're reviewing. I think of it as an auditor. An auditor uses some of the same procedures in auditing as the accountants use in accounting, they have to go through some similar steps.

Now, Tony.

DR. ANDRADE: In my mind I really see this as kind of Phase II of the working group's charter, if you will. Once we have established --

DR. ZIEMER: So that has to do with when it should be done, then?

DR. ANDRADE: No.

DR. ZIEMER: No?

DR. ANDRADE: But really this should be put in the context of what is the product that we eventually want from the contractor on board. Okay. I really believe that that is what drives -- what would drive this kind of procedure.

DR. ZIEMER: Uh-huh (affirmative). Because the last question, there may be a report on an individual review, but what you do with all of those reports --

DR. ANDRADE: Right.

DR. ZIEMER: -- and compiling them into an overall.

DR. ANDRADE: Exactly. And so I think that this would be the work of the working group. It could be a whole new set of members, it could be some members that continue on, but this would be the working group after we've met the next time to look at the administrative part of selecting cases, case availability, case number projection, and that sort of thing. Then the working group would go on to define the work to be done in these particular arenas, and which is basically a task order. And I have -- my own personal gut feeling is that it would be driven very much by what is listed in the

Basic, Advanced, and Blind Review steps that -- that have already been deliberated to a certain extent.

DR. ZIEMER: Roy.

MR. DeHART: Actually, what we'll be doing is primarily overlooking our contractor to assure that they're doing what we're wanting, so in fact, much of this may be feeding back into the task order issues, as well as the basic contract that we're just about ready to approve to go on the street.

DR. ZIEMER: Yes, but I want to make sure, at this point I think it's useful for us to think of our contractor in a sense part of us. Let's keep -- we're not reviewing our contractor at this point. Our contractor is helping us do this review, so let's -- it seems to me it might be helpful for us to think of this in terms of suppose we were doing this with no contractor, we're just doing it, it's us. We really aren't having a contractor help us do some tasks that we can't otherwise do either for lack of time, or in some cases, lack of ability. I -- and I say that in a nice way. We are not dose reconstructionists, okay.

I think Jim was next, and then Mark.

DR. MELIUS: Yeah. Just to follow up on that point. I think that this is going to be part

of developing the task order. We're going to need to have this done before we can do a task order, and I think it needs to start relatively soon because given the schedule that came out, given this OMB issue that will be part of some of these reviews, that we need to get this process underway relatively rapid, and I don't think we can wait for this part, for example, until after the April meeting. I don't think that's what Tony was suggesting, but I don't think we should do it too sequentially because I think if we can get some of this started because if -- if not, we're going to back up the whole process.

DR. ZIEMER: Mark.

MR. GRIFFON: That echoes my concern. I mean I think it's -- I think in developing the procedures I think our task order is going to be more fleshed out, it's going to be kind of a parallel process. And also just -- I was also maybe worried about the sequential because I think either we can put a lot of pressure on the Board to meet sooner again to review these things step wise, and that might, like Jim said, slow down things. We need to get these things rolling.

DR. ZIEMER: Gen.

MS. ROESSLER: And along with that, I think

that this workgroup needs to, whether it's a mock review or whatever it is, needs to go to NIOSH, needs to work with those people, needs to see what they're doing because otherwise, it's sort of like working in a vacuum; you really don't know what their process is until you actually see it.

DR. ZIEMER: Gen, I certainly, in my mind when we were talking about developing these procedures, in my mind the working group has to be there in Cincinnati and -- and I think that's what you're suggesting. And maybe have some sample cases -- real cases where they can step through and say what -- what will a review actually involve, procedurally what do we have to do step wise, and then develop an itemized kind of checklist that makes sure that items are not overlooked, that we're examining the issues that we think are important.

Wanda.

MS. MUNN: This is what I had in mind earlier when I said I see this as a two-step process, and as a two-workgroup process because I don't see the workload being such that the same workgroup could be addressing these procedures as are addressing case selection and the items we were discussing earlier.

DR. ZIEMER: Tony.

DR. ANDRADE: I could see it both ways; however, I think in the -- in the interest of efficiency and in saving time that indeed it probably would be best to proceed in parallel, and so I would suggest -- I'm not pushing anybody here -- but I would strongly suggest that the people who came up with this -- with the Statement of Work, in other words, Mike's, Mark's working group or some members thereof perhaps follow through on working on this. They are the most familiar with the elements of what it is that we are going to want from the contractor, so maybe that's a place to start. I don't know you feel about that, Mark.

MR. GRIFFON: Very enthusiastic. I mean I do want to be involved, even though I know it's going to be quite a bit of work going forward. And I think we have -- have met at a lot of meetings on these issues and we did go to NIOSH, so we have a jump-start on the whole process, so I would certainly be willing to participate in that.

DR. ZIEMER: Who else was on that workgroup? I'm looking to see what our representation was. A fairly good representation cross-section wise in some of the areas of disciplines in the Board we

got. Well, we'll come back to that and ask about these folks' availability and see how their availability, and time, and so on. But thank you, for that suggestion, that helps the Chair, certainly.

Other comments on this? Shall we proceed?

The Basic Report, or what is the product. And I think about these in two ways; one is individually because as I envision it, and again, I'm -- I'm throwing some ideas out and you can shoot them down and tell me they're -- I'm thinking wrong and you have a better idea, or we'll go from there, but we -- there will be individual reports that presumably, and this is based, again, on your workgroup's sort of bottom line thing, and I've summarized a little bit, but somehow we'll be saying something about the adequacy and consistency of the site and personnel data, the adequacy of the interview, and the adequacy of dose reconstruction and probability of causation determination, in some form or another. There would be an individual report of an individual dose reconstruction, and after a time there would be a group of these reports, which might be compiled into some sort of composite that comes back to the Board which

identifies strengths, weaknesses, adequacies, inadequacies. And there again, that remains to be fleshed out. But is this where we're headed, that's what I'm asking, in the review process, is this where we're headed? So let me throw that out for discussion.

Robert.

MR. PRESLEY: I see the group that comes up with the task order being the people that come up with some type of a list or a procedure that we come back to the Board with. If they write the task order, it looks to me like they ought to be able to come up with something that says that here's what we give back to the Board, and it's going to encompass all this.

MR. GRIFFON: Yeah, and a draft, you know, review report -- a report that would to the HHS. I guess that's what you're --

DR. ZIEMER: Well, one of the questions is --

MR. GRIFFON: Right.

DR. ZIEMER: -- who does the product go to.

MR. GRIFFON: Right. Right, right. And I -- I don't disagree with what you've got up here. I think I was envisioning that sort of like a summary

of, over a certain period of time, a summary of types of cases done, and a summary of --

DR. ZIEMER: Oh, sure. Yeah.

MR. GRIFFON: -- you know, the adequacies --

DR. ZIEMER: But the nature of the report, is this kind of information coming.

MR. GRIFFON: Yeah.

DR. ZIEMER: Okay.

Henry.

DR. ANDERSON: Yeah, I would think this is the nature. I would think, you know, we need to, at some point, separate where the contractor will provide us, the Board, with something, and then how do we synthesize that, whether we do it as an annual report or whatever, but at some point I think we'll have the individual cases, and it will be up to us to interpret how they all fit together and put together that annual report, and I'm not sure until you've had a chance to look at them and look for patterns, and the other would be consistency, I mean have they applied the same thing, same approach every time. And you may end up with the same result, but if it's approached in a different way I think we need to look at are we going to recommend, first we have to say if it's inadequate, we could

say it's adequate, but we see there's some room for, you know, some more consistency, or, you know, the approach, so I think that has to be our subcommittee and our group. I wouldn't want to do that summary too frequently, I would say probably on an annual basis, and then that report would be the one the Board sends on to the Secretary, but we really have to do that synthesis in how we do that I think it's hard to flesh that out until you've had a chance to look at at what that produces. But I wouldn't want a contractor to basically be doing our interpretation of it. They're doing the nuts and bolts in pulling it together.

DR. ZIEMER: Thank you.

Tony, then we have Roy, and then Robert.

DR. ANDRADE: I don't disagree with anything that's been said. I think ultimately the report is going to address the very last bullet. It's going to -- in my mind I think it should be some sort of composite from several cases, perhaps a few cases in the beginning; it's -- it really is the adequacy of the dose reconstruction. And the first two bullets may be elements that are culled out specifically in case there's weaknesses, or strengths. But I would only envision an individual's -- a redacted

individual's dose reconstruction being brought to light if -- if some major issue had been found in -- in the review.

DR. ZIEMER: Yeah. Certainly, I don't think any of us envision a report that would --

DR. ANDERSON: No.

DR. ZIEMER: -- cull out individuals, other than say there was an example of something or other, you may not even necessarily identify a site because we need to be careful, but certainly this would be a composite type of report ultimately, based on individual reports.

I think we have Jim, and then --

DR. MELIUS: I think we had somebody else.

MS. ROESSLER: Roy was.

DR. ZIEMER: Roy. I'm sorry, Roy, then Jim, and then Gen.

MR. DeHART: I think the Board has -- also has the obligation that as we're considering policy and procedures for reports that we must consider what happens if we find a fatal error. By that, I mean something that's going wrong consistently and we -- we need to step in and the Board must know how we're going to do that in advance.

DR. ZIEMER: Okay. So we have a lingering

question. I don't know where we hang that right now. And we've -- we've all proceeded as if maybe that won't happen, but we don't want to be like NASA and second guess. And I don't mean that in a derogatory way, either. Unfortunately, sometimes fatal errors do occur, so what do -- what do we do in that case. And this isn't going to be done in a vacuum because there will be periodic reporting, and NIOSH will be aware, obviously, if there are concerns that start to emerge, so I don't anticipate that there will be, you know, out of the blue, surprises, that all of a sudden somebody says you guys have been doing the wrong thing for the last three years. That might occur, I mean somebody might say that, but I think it's unlikely.

Jim.

DR. MELIUS: I actually was going to make the same point, and I hope Larry doesn't interpret that as being any statement on the likelihood that we'll find a problem, but I have nothing more to add.

DR. ZIEMER: Gen.

DR. ZIEMER: On your last point there you mention dose reconstruction and probability of causation. It's quite clear that this is a dose

reconstruction audit. I'm not sure that probability of causation comes into it, only as to how the dose reconstruction inputs to it. I think that part is something that the Board does on an ongoing thing and really is not a part of the audit function.

MR. GRIFFON: I think this is -- I think this is something that Jim Neton has taught us over the working group sessions that I think we're looking at adequacy of dose reconstruction for purposes of POC determination.

MS. ROESSLER: Yeah. I think the wording should be made clear.

MR. GRIFFON: Did I get that right?

DR. ZIEMER: Well, yeah, and they simply end up being linked here because POC is basically the outcome of the dose reconstructions. Yeah, point well taken.

MR. NAMON: Dr. Ziemer, I'm just going to point out that there's also kind of a legal distinction there because the POC determination is not made by the Department of Health and Human Services.

DR. ZIEMER: Yeah. Yeah, understood. We'll just consider it in this last one, strike the POC from our minds, it's not really there virtually.

Okay, Henry.

DR. ANDERSON: Yeah, I was just going to follow up on Roy.

DR. ZIEMER: The jury will disregard the POC.

DR. ANDERSON: Jim's comment was, I think going two steps back when we have kind of procedures, you know, any -- any problem will appear as a first case, and it would seem we just need to have the flexibility in our case selection that if something looks like there may be a problem, we would then immediately move to look at other similar cases, so you would have an investigative process there that it wouldn't say there's a fatal flaw based on a single --

DR. ZIEMER: Right.

DR. ANDERSON: -- case. You'd want to see is it a pattern, and so we would then -- we just need to have that procedure in place to move forward from there and have that flexibility.

DR. ZIEMER: Thank you.

Robert.

MR. PRESLEY: When we talked about this in the working group we talked about a -- a group, subgroup coming in and reviewing, before our meeting

with our contractor, the cases that we had selected. And then the way we had envisioned this -- and Mark, jump in here if I'm wrong -- is that we would come into the Committee as a whole with a recommendation that we've gone through X number of dose reconstructions, and that we find those to be adequate and correct, or we find 11 out of 10 -- or 11 out of 12 to be adequate and correct, and we found one that we would like to send back and have some work redone on it at that point in time so we don't wait, so I -- I consider something, some type of a report to be done monthly, or every time we meet, and then down the road, maybe a yearly report back to the powers that be.

DR. ZIEMER: Right. And actually, that -- that issue becomes part of our procedures for the review; what is the output, and that can include the frequency of reporting to the Board, the frequency of reporting to the Secretary of Health and Human Services, or whatever. Those -- those remain to be refined. I -- I hadn't envisioned, for example, sending a letter to the Secretary every month telling him what the findings were, but -- and I'm sure he's not interested in that either, but an annual report might be quite appropriate. But

certainly the Board wants to be apprised on a regular basis.

DR. ZIEMER: Other comments.

David, please.

MR. NAMON: Just one general point I wanted to make sure the Board was aware of, which is that for this whole review process there's going to be some significant proxy considerations to take into consideration, not the least of which is that the Subcommittee and the Board operate in public, and identifying individual claimants is a significant problem. Ordinarily, we would have to redact reports to the point where they're not recognizable to someone who would have been a coworker of that person, so, which is obviously a pretty significant concern. So just something for you all to keep in mind as you're considering how this is going to work.

DR. ZIEMER: Yes, and I don't think the Board anticipates discussing individual cases in Board meetings. The reporting would always be done in terms of groups, statistical summaries of cases reviewed and that kind of thing. Is that not everybody's --

Robert, you have a comment?

MR. PRESLEY: Yes. On that, what we have talked about in the Committee is coming up with a group to do these with an alternate, and if somebody recognizes that, say Savannah River, they worked at Savannah River, then they would excuse theirself and the alternate would step in. That's the way we were envisioning this happening, right upfront.

MR. NAMON: I think you still have the concern that if the Subcommittee is operated in public that -- that you'd still face the possibility that the people who are involved would be discussing matters that the public would then be able to identify individuals. I'm sure this is something we could work out if the time comes, but I wanted to make sure that you all were aware that there be a need for significant redaction.

DR. ZIEMER: Thank you. And we are certainly aware of that.

Henry.

DR. ANDERSON: Yeah, it seems to me that if there is something where details need to be discussed by the Board we do have a mechanism to have it be a closed session, just as we did when we talked about the financial aspect; so it's one thing for the written report obviously, to be sure that,

you know, that doesn't have any detail, but if -- if an issue comes up that becomes, you know, where there's disagreement on the review group or something and we need to go over the specifics of a case, it would seem that we could, in fact, close that from the public for the discussion of confidential information just as we did with the contract discussion.

DR. ZIEMER: Further comments on this item?

(No response.)

Now, I have one other item which I'm debating in my own mind whether to show you. How many want to see it?

DR. ANDERSON: Go ahead, take a chance.

DR. ZIEMER: What -- well, I'm going to hold it until after the break.

What I have is a -- I'm still -- I'm still trying to make sure we're on the same page as to what a Basic Review report looks like, and the starting point is the Individual Review. And I have kind of a strawman Individual Review report, and then the only reason for showing this is to make sure content wise that we have captured the salient points that need to be in the review. And this would serve then to assist the workgroup which would

come up with that. They can use it as an example of what not to do, or they can use it as an example of what they should do, or they can start from scratch. But we'll save that until after the break, how about that. So let's take 15 minutes and then we'll -- oh, a comment first.

MR. ELLIOTT: We -- we were just kibitzing here a minute about Henry's comment. It's not clear to me that we can go into closed session for that purpose, whether the Privacy Act requirements would trigger a closed session. We're going to -- I'm asking the counsel to check into that because I think that is important for us to determine.

DR. ANDERSON: Yeah, that would solve a lot of problems if we could.

MS. MUNN: But that's not clear to me, either. It was my understanding that Executive Sessions related only to personnel and legal matters.

MR. ELLIOTT: And financial. Let me, for the record state that all the Board members are bound by the Privacy Act as special government employees. The contractor that you will hire will be bound by the Privacy Act. But when you come before, into the public meeting, we -- we have

problems and we need to be very careful and diligent in our redaction efforts are -- are making sure that no one can determine who might have been talking about in a public forum, so.

(Whereupon, a break was taken.)

BY DR. ZIEMER: (Resuming)

We'll delay the administrative housekeeping for just a little bit because Cori has some things she needs to take care of first. So I think we can continue with issues related to completed dose reconstruction reviews.

Let me remind you that we still have before us the -- the issue of the decision on who will administer the contract, do the procurement on behalf of the Board.

Also, I want to finish what we were talking about here, and maybe we'll do that first and then move to the procurement issue.

The last thing that I talked about to show you is based on -- I will need the slides up -- is Jim here?

MS. DiMUZIO: No. I will.

DR. ZIEMER: Okay. Yeah, it's that one. Just open that. It's a Word document. This is not a Power Point, it's a Word document. I just want to

go through that.

Now, for reference, if you would move into the tab called Discussion Documents, the Request for Contract document, and go to page 16 and 17; page 16 and 17 was the Basic Review. Now, what I did here, and I see already that sometimes when you close these programs and reopen them the automatic formatting overrules everything you did.

DR. ANDERSON: You mean 1 and 2 aren't the most important?

(Laughter.)

DR. ZIEMER: In any event, the only thing I did here was take the Basic Review items as they are here, and I've transformed them into a form format. Now, this -- this serves two purposes: I'm really asking the group is this what we want an Individual Review Report to look like? I don't know if we do. Or does it at least capture what it is we want on the Individual Reviews. And we don't have to -- we don't have to come to an approved form here because this clearly is going to go to the workgroup. But just as a point of guidance for the workgroup, all I did was, you know, this was something that I just ended up doing after I was thinking about the other stuff last night, I asked myself the question what

would a review report look like. And based on what was here, I just put it in this format.

So let me just put it out here, and we don't have -- you can react to it or whatever, but -- and I don't know if there's a way I can move this up and down. Probably not.

So I have Henry -- can you sit there on a chair Henry, to just -- well, don't change the zoom.

DR. ANDERSON: I was going to make it smaller and then the whole page will be there.

DR. ZIEMER: Yeah, and then we won't be able to read it. It's hard enough to read it. Just go over to the side there -- yeah, we can scroll it.

Okay. So it says: Were all requested data from the site received or obtained? Yes. No. Comment.

I don't know if that's adequate. Were data -- were the data, should it say: Used for documentation of POC or we should say of dose reconstruction -- it's a new abbreviation for dose reconstruction -- adequate? Yes. No. Comment. And then a whole section of questions relating to interview: Were incidents or occurrences appropriately addressed? Yes. No. Comment. Were monitoring practices appropriately addressed? Yes.

No. Comment. Were personnel protection practices appropriately addressed? Were work practices appropriately addressed? And in all of these cases it's: Yea. Nay. Comment. And maybe all of these can't be answered by yes or no because it may not be clear cut. Is the interview information consistent with the data used for dose estimate? If -- and here -- wait, go back -- If no, is there reasonable justification for the inconsistencies? Again, this comes out of the document. It's a little different than just a pure comment.

Yeah.

MR. GRIFFON: Yeah, I think it's a good starting point. I mean I -- I'm glad I didn't draft the same thing last night because I was thinking similarly. And I think that this would be a good starting point since I have to kind of test this form and see if it's sufficient and --

DR. ZIEMER: That's right. You actually -- it has to be tested with some real cases and so on.

Were the assumptions used in the dose determination appropriate? Yes. No. Did the assumptions used resolve issues in favor of the claimant? That is, give claimant the benefit of a doubt. Were the dose calculations appropriate and

sufficient for determination of -- again, we should say dose reconstruction. Actually -- actually, this is the right question --

MS. ROESSLER: That's okay. Yeah.

MS. MUNN: Uh-huh (affirmative).

DR. ZIEMER: -- were they appropriate for determination of probability of causation. Were the data used consistent with rad monitoring protocols? Was the treatment of missed dose done properly? Was the treatment of unmonitored dose done properly? And then I put a catchall in.

So, I guess the only thing I'd ask here is this sort of along the right track?

MS. ROESSLER: Yes.

MR. PRESLEY: Yes.

MS. MUNN: Yes. You're fine.

DR. ZIEMER: Okay.

DR. MELIUS: Can I?

DR. ZIEMER: Yeah, Jim.

DR. MELIUS: I think it's along -- I think it is along the right track in terms of the report that we would have for the Board, how it would be reported back to the Board. I'm thinking that as the Board or the workgroup -- however we, you know, set that up -- works with the contractor we probably

want a longer form where they would fill in details. And this might address some of these privacy --

DR. ZIEMER: Well, in fact --

DR. MELIUS: -- issues also that would --

DR. ZIEMER: -- I'm actually looking at this as a report on an individual one right now because you would have to pool this to get your composite, and in the comments part maybe needs to be fleshed out in a different way, but more specifically.

DR. MELIUS: Just thinking about it though, I would think that with the Board members interacting with the contractor, they're going to -- I would think that we would want the contractor to provide more detail in a report to the Board members on that --

DR. ZIEMER: Oh, I'm with you, yeah, yeah.

DR. MELIUS: -- I would think that it would include a work history kind of summary that would then fill in some details --

DR. ZIEMER: Right.

DR. MELIUS: -- of -- of what kind of personal protection, what --

DR. ZIEMER: This is more like the executive summary.

DR. MELIUS: Exactly. Yeah, yeah, yeah. I

think that's -- this kind of thing would be appropriate to come back to the Board, the overall Board, that it would be the basis for, you know, a summary report and provide, you know, the categories and the consistency for that. But there may be another form on top of that, that they would -- so I think -- the point I was trying to make was I think as the workgroup works on the procedure for review and does some of these mock reviews and so forth, that I think they will, you know, sort of develop a series of forms, and one will be a more detailed one, then one less detailed one according to that. And then they have to make sure that the detail would cover each of these points.

DR. ZIEMER: Good.

Other comments?

Now, we may be ready to move to an actual appointment of a working group, I think on at least or some or all of these tasks that we talked about this morning. Are we at that point? Are you ready to do that? This would be a workgroup just to get this process underway. This is not a subcommittee that's going to do this long-term. This is a workgroup that would deal with initial identification of the available cases, initial

determination of a case selection process, initial development of procedures for selection of cases, and procedures for the review of cases. Those are the main issues that we talked about. Now, and we had a little discussion about whether that's all that this one Subcommittee, or one Workgroup, or whether -- whether the actual procedures for the review is a separate group, or a follow on activity. It may be that one group can dig in and do all of these things and then they would report back, at least at the next meeting, and tell us where they are on it.

Did you have a comment, Mark?

MR. GRIFFON: Well, I was just going to say that I also saw a parallel test with the procedures was the drafting of some of the task order language.

DR. ZIEMER: And the task orders, right.

MR. GRIFFON: Yeah.

DR. ZIEMER: Then let me ask, again, those who were on the previous workgroup, let's reidentify here. Mark chaired it, and we had Roy, and Robert, Gen, and Rich. That's two, three, four, five, five individuals. Let me ask if you five are interested and available to participate in this -- this next workgroup activity. I don't -- I don't think you

need to feel obligated in terms that you know your own schedule, but you also have some familiarity with the -- the thinking process that went into developing those procedures.

Roy.

MR. DeHART: I'm certainly interested, but I will be out of country almost for the entire month of April. That tends to be a critical time.

DR. ZIEMER: So we may need to find someone for you.

Robert?

MR. PRESLEY: I'm available.

DR. ZIEMER: Available.

Gen?

MS. ROESSLER: I'm interested and I'm available. It kind of depends on how much time it will take and when. I mean I have my calendar with me. I think I can work it out.

MR. ESPINOSA: Is the intent still to have the working group sessions or working group meetings prior to the Advisory Board?

MS. ROESSLER: That's what I thought.

MR. GRIFFON: I think we'd have to have them separate, yeah.

MR. ESPINOSA: I mean it won't happen like

-- I mean we're not going to piggy-back the Advisory -- we won't piggy-back the Advisory Board?

MR. GRIFFON: We may. It may be both.

MR. ESPINOSA: It may be both.

MR. GRIFFON: I would see at least a need to go to Cincinnati as a separate meeting --

MR. ESPINOSA: Okay.

MR. GRIFFON: -- not necessarily tied in with a Board meeting, and depending on what we find out about SEC Rules, but not necessarily tied into that.

DR. ZIEMER: Tony.

DR. ANDRADE: Paul, I guess I would suggest perhaps getting a sense of the Board on whether starting two parallel efforts with smaller scopes of work. In other words, one looking at procedures in developing the task orders, for example, that might be a one-day activity, or even less; and then the other, developing the administrative procedures for case selection, case availability, and that sort of thing. If -- if we can reduce the work scope and have two working groups, so to speak, you know --

DR. ZIEMER: I understand that. My concern would be the degree of overlap, and the fact that we need to have this all on the same page in a sense.

Comment, Jim?

DR. MELIUS: Could I suggest an alternative to that, but maybe capture some of that. We could have the initial workgroup get the process started, and then as they define other tasks that need to be done or refine those, and then we look at people's availability over time and so forth because there may be periods of time when people aren't available. It may be that that will be how it would work out. If this initial workgroup came back to us at the next meeting with sort of an update where they stand, what they see needs to be done --

DR. ZIEMER: How far they've gotten.

DR. MELIUS: -- how far they've gotten, what needs to be done, and then, you know, we have enough people and time to do it in, then I think we can sort of decide from meeting to meeting, and it may very well then make sense for, you know, split the workgroup or bring other people in for particular -- particular tasks and so forth.

DR. ZIEMER: Gen.

MS. ROESSLER: Just picking up on what Jim and Tony have said, I like the idea that Tony brought up of people rotating on and off this group; you'd have maybe a consistent core or consistent

over a period of time, then as the need comes up, and I could see this almost, you know, maybe in the second meeting of the group that somebody rotates off, somebody comes on that would be more familiar with all the sites and could help with the site selection; I'm thinking of Mike, for example, someone like that with a specialty need rotate on.

DR. ZIEMER: I want to caution you that we're not thinking in terms of a long-term group with people rotating on and off. We're talking about a short-term working effort or task. This would be a workgroup that reports back at our next meeting, and then we will decide whether additional work needs to be done. They may complete everything by the next meeting. This is not a group which is going to be involved in necessarily monitoring the dose reconstruction activities over the next year. This is a group to address these immediate tasks of getting some procedures into place.

MR. GRIFFON: Yeah, I had just a comment on what Tony said. I was thinking also about that, concerned about overlap, and, you know, cause there -- there could be an obvious break here with the procedures and the task order parts, and then the selection criteria part, because the -- how are we

going to stratify, what kind of sampling processes are we going to use, that kind of work. But I think there would be a little bit of overlap, and I -- I wouldn't mind that our group take a first shot at that.

The other thing is that I think to do the selection criteria, and the -- and the identification of the cases is also going to require some distance, and if one group is already there initially, you know, I think we can probably.

DR. ZIEMER: My inclination is to ask the A-workgroup to get this underway. It may be that they can report back at the next meeting, and then we can see whether or not either they or some modification of that workgroup needs to do some additional work to complete the tasks. And that would be what I would propose, and what I'm moving toward here, I appoint this -- would be to appoint those available who had been involved in that process who are familiar with the thinking, but we need to, for example, find someone to -- if Roy's availability is in question, maybe somebody who can fill that seat, as it were.

MS. ROESSLER: I thought Roy was a very valuable part of this group in the first assignment,

and I would suggest that we first look at our calendars and see if we couldn't involve a time when he could be there.

MR. DeHART: I have the remainder of February and all of March, and would be pleased to try to adjust my calendar to be available, even though I will be gone.

DR. ZIEMER: Let me suggest the following: I will appoint the workgroup and maybe have at least one alternate available.

Do we have a limit on numbers on a workgroup? It has to be less than a majority of the Committee membership, which would be six. We can't have seven, but we can have up to six.

We have one, two, three, four, five. And the Chair might want to be present just to observe, which would give us six, but who is -- Tony, are you interested in being an alternate?

DR. ANDRADE: (Nods head affirmatively.)

DR. ZIEMER: Anyone else interested in being an alternate?

MR. GIBSON: Yeah, I would be.

DR. ZIEMER: Mike, okay.

DR. MELIUS: I would be willing to, depending on availability, and time, and the issue,

I'd be glad to help out, so.

DR. ZIEMER: I will ask Mark to serve as Chair, if you're willing to, Mark. And then Roy, and Robert -- Roy DeHart, Robert Presley, Gen Roessler, and Richard Espinosa to serve on the workgroup; for Jim Melius, Mike Gibson, and who else, Tony Andrade --

MS. MUNN: And I could do that.

DR. ZIEMER: -- and Wanda, and Henry, are all available as alternates.

MS. MUNN: All available. Uh-huh (affirmative).

DR. MELIUS: Let's not forget Leon.

DR. ZIEMER: So we have a number of folks available as alternates. This workgroup would proceed to develop the procedures for identification of available cases, the case selection process, procedures for the selection of cases, and parallel to that, the development of task orders, and, if there's time, procedures for the review of cases. But they will report back at our next meeting on their progress and with any recommendations that they have at that time based on their experience. They may, by that time, have some specific recommendations and they will have a better feel for

the nature of the time needed to complete the tasks, and whether it can be done by that workgroup or whether we have to go beyond that.

I don't think it requires Board action for the appointment of a workgroup. I think the Chair is empowered to do that. Of course, any group is empowered to challenge the decisions of the Chair by motion, but if that's a group -- are there any objections to that?

(No response.)

DR. ZIEMER: There appear to be no objections, so we will proceed on that basis. I will ask the Chairman of the working group to work with the individuals to find a suitable meeting time. I think you can do that individually, you don't have to do that as a group.

MR. GRIFFON: Before we leave, I would propose maybe we can all get together and look at our calendars.

DR. ZIEMER: And let the Chair know what your plans are.

And, Larry.

MR. ELLIOTT: Just for the record, you've clearly defined the charge for the working group.

DR. ZIEMER: Yes, I --

MR. ELLIOTT: That's one thing --

DR. ZIEMER: The charge was to develop procedures for identification of available cases, to develop a process for case selection, to develop procedures for the selection of cases, and procedures for the review of cases, if there's time. Those are the tasks that this workgroup is supposed to do, and in parallel with that, develop a task order.

MR. GRIFFON: The other thing as far as scheduling a meeting with the working group, we might want to ask Larry when is a good or bad time to be at NIOSH and availability of staff, things like that.

DR. ZIEMER: It's always a good time to go to Cincinnati.

MR. PRESLEY: Or is Jim going to be able to help us on this?

DR. ZIEMER: Well --

DR. NETON: I was just checking.

DR. ZIEMER: Well, can I ask that you all work that out?

DR. ANDRADE: A quick question. Do you want this initial working group to at least brainstorm on case selection criteria as part of their charge?

DR. ZIEMER: Yes, that's one of the -- that was a part of it, yes. Didn't I say that? Yes, that is definitely part of it.

Now, I'd like now to focus on -- I'm going to focus on the issue of the procurement. We -- we have discussed already two options; one option is to proceed with the procurement under CDC; another option was to have the procurement done through the Department of Labor. Let me ask first if any Board members wish to identify any additional options?

(No response.)

There appear to be none. Then I propose we'll proceed as follows: Number one, if the Board wishes to proceed with NIOSH/CDC as the procurement agent, then no action has to be taken because that's the track we are currently on. If the Board wishes to utilize the Department of Labor as the mechanism for the procurement, then we will ask for a formal motion to do so. And so the Board -- and so the Chair will now entertain a motion, if anyone wishes to make a motion, to move the procurement to the Department of Labor. Is there anyone who wishes to make such a motion?

(No response.)

DR. ZIEMER: The Chair hears no such motion.

In the absence of a motion, I will declare that we will proceed with the procurement through Centers for Disease Control, and instruct Larry to proceed along that path.

And we have some idea of what the timetable is, based on yesterday's discussion.

Now, I'd like to ask the working group that prepared the document -- Request for Contract document, if they have any additional changes or modifications that need to be made in the document before we proceed with the procurement? You will recall yesterday Larry indicated that if they are -- if we are to proceed right away we need to confirm that this is the document.

Mark.

MR. GRIFFON: We had -- you probably recall the end of last meeting I had worked with some other folks on some draft amended language for Attachment A, specifically in the Conflict of Interest section there was concerns on the language being too, I guess, too limiting, and we wanted to make sure it was consistent with an evaluation of conflict of interest rather than -- rather than eliminating all possible bidders, so we did redraft an Amendment and I would propose to offer that now for -- to amend

Attachment A.

DR. ZIEMER: Could you identify specifically the section and part of Attachment A?

MR. GRIFFON: It's Attachment A, Section E, Conflict of Interest.

DR. ZIEMER: And item number?

MR. GRIFFON: The entire section.

DR. ZIEMER: Give us a paragraph. This is for the recorder, so --

MS. ROESSLER: Paragraph E.

DR. ZIEMER: All right. Give us a page number.

MS. ROESSLER: Page 9.

MR. GRIFFON: It's page 9 --

DR. ZIEMER: Page 9.

MR. GRIFFON: -- on to page 10, it's Section E.

DR. ZIEMER: And the particular paragraph?

MR. GRIFFON: It's the entire Section. We've amended the language for the entire Section. Some of it will be similar, but I -- and I have that available if we want to get to it.

DR. ZIEMER: I think we need to identify what the change in language would be. Okay. We -- we have that on a disk. It will take just a minute

to load that, and while that's being loaded, can you describe for the Board the nature of the change in language that is being proposed before we actually see the words?

MR. GRIFFON: In a nutshell, I'll try. Basically --

DR. ANDERSON: Is it here somewhere?

MR. GRIFFON: No, it's -- I've got to get it on disk and give it to you.

Basically, we attempted to, rather than have criteria that said -- that looked at, for instance, the potential bidder's work history with DOE, AWE sites and we said that -- I think the language as it exists now says something to the effect that if they've had any work --

DR. ZIEMER: In the past two years.

MR. GRIFFON: -- in the past two years, then they're excluded from even entering in, you know, it's a black-line sort of criteria, and we rewrote that to say that that work history with DOE, DOE contractors, etcetera will be considered in the evaluation of conflict of interest, but not necessarily an exclusionary statement. I guess that sort of summarizes.

DR. ZIEMER: Okay. While the words are

being detected and selected, and put up, we can discuss this.

DR. MELIUS: On a related issue to how NIOSH is going to manage the contract, and I guess -- I don't think we -- I don't believe we've talked about it before, at least not directly, at least I don't recall, is to how it would be managed within your group, Larry, within OCAS, or is there an alternative for technical or contract oversight within other agencies, other parts of NIOSH, I should say, or other parts of the CDC? And my concern is that -- that there be an issue that comes up where there is conflict between the Board, or -- I don't want to say conflict -- disagreement between the Board and you or your staff over what could be done, or how the contract is being handled, or the oversight provided for that. And that that would -- that you or your staff would be telling the Board that no, we can't proceed with this task or whatever, or access to records, or something like that, or the process that would -- and you would be telling us no, we would want to go forward, and that would, I think, put you and your staff in a very awkward position. It would be, you know, in appearing to -- appearing to be impeding our review.

And I just didn't know if there were alternatives in terms of either technical or contract, or say that it was being from another part of NIOSH or a part of CDC that would help to obviate that issue.

MR. ELLIOTT: The only time that anyone would be saying no to this Board in a task order format is when you put something on the table that would be outside the boundaries of the FAR, so outside the procurement requirements. We're going to be, as I said earlier, walking a very fine line here to make sure that we don't influence the Board's direction otherwise, so. Are there other places within CDC, I think there's one CDC Procurement Grants Office, that's where this will go to, you know, so that's where the contracting officer will be. It will -- Martha DiMuzio, as my program analyst, will monitor the expenditures. We have to keep that inside OCAS because that's where the funding -- funding source is, otherwise we have to do some transfer of funds and that becomes somewhat problematic, as you may know; so certainly I don't see any conflict in that regard. I think we will, of course, need to have a -- what's called a technical monitor assigned to this procurement that serves as the contracting officer's technical

liaison, if you will, to make sure that what the Board's task orders are as they come forward if there are questions at the contracting officer level that somebody can explain, a technical background. We are fully aware of where we stand in this regard, and, you know, we're going to march accordingly to make sure that we don't appear to be, again, influencing or providing direction to the Board. This is your -- your work and your product; we're just going to serve to facilitate it. That's all I can do to answer your question.

DR. ZIEMER: Jim, let me also add to -- to the discussion that ultimately this Board reports to the Secretary of Health and Human Services, and I would suppose that in the unlikely event we had some kind of a major disagreement on some issue that an appeal could be made at a very high level, which would certainly --

DR. MELIUS: There are possible situations; for example, review -- more in-depth reviews, about access to records, obtaining records, and so forth that I think could become problematic. I'm not saying that we need an alternative, but I -- I think all those procedures need to be worked out fairly carefully so that we try to avoid conflict or a

potential problem in -- in terms of this issue, so we don't put NIOSH in the position of -- or the Board in the position of being in conflict with NIOSH, and you -- you know, Larry, and Larry's staff being seen to hold up or attempting to thwart a quality review. And it may not -- you know, again, I'm not saying it's going to be somebody's fault doing it purposefully, but just giving the appearance of doing that, and -- and I think we need to think about it. Maybe that's something as we get along. I don't think it has to be done now, but as we get along with the task group, the working group ought to be thinking a little bit about it as they outline what the procedures are going to be for you, and is there a potential -- are there potential problems with access and information, what do we do in those instances, and so forth.

MR. ELLIOTT: I just can't envision or imagine -- maybe you can help me out here. In your example, where, how would it come about that you would be limited in access to information or records? I mean --

DR. MELIUS: Well, if there were long delays in obtaining information, or if there was problems with trying to obtain additional information, which

could come up in terms of the more in-depth reviews, so -- because remember, the more in-depth reviews can be some way at looking at how complete and thorough you -- your staff was, or your contract staff was in obtaining information.

MR. ELLIOTT: But these are completed dose reconstructions; they are a snapshot in time, so whatever information was used, whatever site profile was available at the time to complete the dose reconstruction should abe already in the house, in our hands, and you have immediate access to it.

DR. MELIUS: Yes, but we're going to be looking at how adequate that was, was there missing information.

MR. ELLIOTT: If we don't have the information, how can we limit your access to it?

DR. MELIUS: Well, because we will be looking for additional information that you missed, and there's, I mean -- yeah, yeah, and from DOE. I mean it's not --

MR. ELLIOTT: Well.

MS. ROESSLER: If you can't get it, you can't get it.

MR. ELLIOTT: I don't know how to answer this question because I just can't -- I can't seem

to conceptualize the instance --

DR. ZIEMER: It doesn't sound like a situation where NIOSH is attempting to thwart the review process.

DR. MELIUS: The -- the issue is going to be how the -- the conduit to getting information, for example, from DOE, is going to be the -- NIOSH. We're not going -- the Board is not going directly to DOE for information. And you have the same issue --

DR. ZIEMER: Well, you're perhaps identifying something where the Board might be seeking more information from DOE, where in the normal review process we might -- the review might identify that some information is inadequate; whether the review has to actually go out and therefore get that information is -- it seems to me is a separate issue from the review process. The review process is -- is in place to identify, for example, adequacy or inadequacy. If it's inadequate, then that is reported, whether now something has to be reopened and more material, it seems to me now is something other than the review process, but I -- that's how I'm reacting to that.

MR. GRIFFON: I mean this is the question

that we've thrown around for a while on the Board, but I guess a question of was sufficient effort put forth in the dose reconstruction process to obtain all of the relevant records, and if -- if -- I can see a situation where NIOSH would say well, we knew these other documents existed; we -- we had a general description of them; we deemed them not relevant. And the Board might say well, you know, for whatever reason they feel that they want to look at those documents and make sure that they weren't relevant, just not, you know, inadvertently overlooked, you know, something like that.

DR. ZIEMER: I think what I'm saying is it seems to me that if the Board makes that judgment, they can make the judgment saying that we, for example, think these documents should have been obtained. You can make that judgment -- you don't necessarily need those documents to make the judgment because once you get the documents, you can say sure, look, they really were inadequate, or, oh, you were right, they weren't. But the judgment is that you should have had the -- we think you should have had these documents, right. Do we need the documents to make the judgment.

MR. GRIFFON: Well, if -- if -- you know, if

you get in that situation where they say well, you know, we had a general summary of what those documents were, we believe they wouldn't have been, wouldn't have been relevant and, or significantly affected the outcome of the case, how does an auditor sort of test that, you know, without having the actual documents themselves. That's the question.

MR. ELLIOTT: Well, how do we establish the basis of that without seeing the documents ourself? So I don't see us doing that, I think we have to have the documents in order to say they're not relevant.

MR. GRIFFON: I'm just -- this is hypothetical.

DR. ZIEMER: Yeah, there's a lot of hypotheticals here.

MR. ELLIOTT: I don't see -- I don't -- I truly don't see us holding you up. I don't see us interfering; in fact, we're walking this fine line because on the other side of the line is we could use you to our best advantage to pressure DOE, you know, and there becomes in that, in and of itself, another conflict, if you will. I mean we want this information, we want to push DOE to give us this

information; we apply pressure as best we can, and we leverage them. And certainly this Board has -- has an opportunity to do that for us, okay.

DR. ZIEMER: In fact, it would seem to me that if -- if this Board saw a pattern where we felt that there were lack -- there was a lack -- consistent lack of adequate documentation that we could in fact go to NIOSH with this information and they could in fact, once we made such a judgment, go back to DOE, for example, and say our Board has told us that we need to get more of whatever it is, so, in fact, could use it as a pressure point for a future date.

But I think the point is made, Jim. I think we hear the point and the Subcommittee has, and --

DR. MELIUS: Very seriously.

DR. ZIEMER: -- and I'm not sure what more we can do on it today except to be alert and to ask that that be considered as we go forward.

DR. MELIUS: That's all I was asking.

DR. ZIEMER: Right. Thank you.

I kind of lost track of where we were. Oh, we have the --

DR. MELIUS: Waiting for Mark to get this up on the screen.

DR. ZIEMER: We have the language up there, so we want to, for the record indicate the proposed changes in Item E, Conflict of Interest. The first paragraph --

MS. ROESSLER: It's not the same.

DR. ZIEMER: -- is not the same.

MS. ROESSLER: He doesn't have the same document. I thought you were going to put what we have here in front of us and then indicate the changes.

MR. GRIFFON: Oh, the last one, oh, no, it's different.

MS. ROESSLER: Maybe I'm looking for something different.

DR. ZIEMER: Is this a proposed change in the whole Section E?

MR. GRIFFON: The whole Section E is -- is revised, yes.

MS. ROESSLER: So we need to compare what's up there with what we have in this.

MR. GRIFFON: And you'll notice as you read -- I wish -- I should have got printouts of this actually because it's hard to read from the screen.

MS. ROESSLER: It is.

MR. GRIFFON: I don't know if we -- if

that's something we can do fairly quickly, but if you'll -- you will notice similar language as you go through these paragraphs, but things have been moved around, and -- and we grouped -- I grouped something kind of called a Conflict of Interest plan, giving that 10 points, and the Work History, giving that 15 points. And there's criteria such as those hard-line criteria are removed, so it's more up to the evaluation panel to consider their work history, rather than an exclusive, you know, hard-line decision.

DR. ZIEMER: Okay. Let me ask the Board a question here: Would you like to get some hard copy of this and then have a chance maybe later in the morning or right after lunch to bring this to closure? It's a little hard to work on --

MS. ROESSLER: I have a suggestion that might make it faster. I mean what I did was read through what we have here, identified what I thought were the key points, and there are about five of them, and then just evaluated it for what it is. And what I, based on our discussions before, and as far as I'm concerned I've gone through every point and I feel that he's addressed them all according to our recommendations, and well. I only have one

question. I don't know if other people would find that efficient or not.

DR. ZIEMER: But built into this is a change in the two-year requirement as I understand it, Mark, is that correct?

MR. GRIFFON: That's correct.

DR. ZIEMER: Mark is proposing that the two-year requirement be dropped in favor of it goes to a nonspecified time period and simply says that that's one of the things that gets --

MR. GRIFFON: Right. For instance, that one paragraph says greater emphasis will be placed on work experience within the past two years. But it doesn't exclude a bidder if they've worked DOE, AWE, etcetera, etcetera in the past two years, so.

DR. MELIUS: Can we get a -- for now, I think it's a lot easier.

MR. GRIFFON: I think it would be easier.

DR. ZIEMER: Yeah. We'll ask if we -- if we can get the printout so we each have it sort of side by side, that will be helpful. And we'll take care of some of other business in the meantime, and then return to this. Is that agreeable?

MS. ROESSLER: Yeah. So Mark, you --

DR. ZIEMER: And we have an issue of whether

we can get a printer here.

MS. HOMER: I'll have to take it to the front office and see if I can find somebody that has this on their computer. They don't have a business center at the hotel, so.

DR. ZIEMER: Is there a Kinko's close by?

MS. HOMER: There is something close by.

MS. MUNN: But we don't have an interim edited form that shows strikings and moves and.

DR. ANDERSON: Well, this is all different.

MR. GRIFFON: It was -- see, it was totally removed, so to redline, strikeout, it didn't make sense the way the changes are made, yeah.

DR. NETON: It looks like it's only about page 1 on here.

MR. GRIFFON: Well, I would actually say -- and now I'm going to -- I remember this. The Attachment A, if you go to the very top, Jim, there's a couple of other changes. These were taken from Section -- removed from Section E and put as overriding factors. And because these are hard-line, I believe these were hard-line criteria that could not be, you know, you can't evaluate a bidder on -- these are basically, if you meet one of these you cannot bid, so I pulled those up front because

it sort of doesn't make sense to -- to give points -- they're not even allowed to go through the process is what this is saying, so those were pulled up front out of Section E. I think the language remained more or less the same as it was in the original draft.

DR. ZIEMER: Well, wait a minute. Section E --

DR. ANDERSON: Of Attachment A.

MR. GRIFFON: Of Attachment A.

DR. ZIEMER: Of Attachment A, okay.

MR. GRIFFON: So I think a printout would be helpful --

DR. ZIEMER: Yeah. We --

MR. GRIFFON: -- of the whole thing.

DR. ZIEMER: -- we do need to do that. Let's -- and that may be -- well, originally my thought was that we could kind plow along and maybe even have a late lunch and finish up our business, but maybe that -- we'll see what we can do to get this printed up. In the meantime, let's try to take care of some other issues.

MR. GRIFFON: It's on that disk.

MS. ROESSLER: We need two Coris.

MR. ELLIOTT: Well, I'll fill in for in for

Cori while she's running this down.

MS. HOMER: Well, what we could do, is I could do housekeeping, and then run this down and get it printed and everybody break for lunch while I do that.

DR. ZIEMER: One possibility, and I had earlier given members of the public a heads-up that we might want to move that Public Comment Period up. Could I ask if there are members of the public who did wish to address the Board, and who are here, and willing to that at this time. Are there any members of the public who were planning to address the public this afternoon -- or to address the Board this afternoon?

MS. HOMER: Nobody's signed up.

UNIDENTIFIED SPEAKER: Nobody's signed up.

DR. ZIEMER: Nobody's signed up to address the Board. Okay. Is there anyone here who is wanting to do that at 2:45, and insists on waiting until then?

(No response.)

DR. ZIEMER: Okay. Just as an informational item, Robert Presley.

MR. PRESLEY: I was asked to bring this in front of the Board. The Department of Labor has put

out a booklet/pamphlet called Frequently Asked Questions, and it's been passed out in Los Alamos, and Oak Ridge that I know of. And I have had two individuals come to me and say that it's causing some problems. The problems are: When the individual goes to the doctor and says that I have a problem, I need my bills paid under workmans' comp, the doctor immediately says oh, have you filed a -- under the --

MS. MUNN: EEOICPA.

MR. PRESLEY: Yeah. OWA -- I'm sorry. The sick-worker bill, and if their answer is yes, then workmans' comp doesn't cover this, you need to go to the sick-worker bill. So they turn around then and get on the phone and call the 1-800 number and try to get paid, try to get what they have to do to set up appointments, and they say no, you have to go back through workmans' comp. So apparently all this is, is causing more confusion and consternation than it is doing good. And I don't know what to do about it, but I was asked to bring this in front of the Board as a problem.

And I think Mark has had, or heard some of the same problems that I have, so it's not -- it's not just a one -- you know, one person having

problems with it.

DR. ZIEMER: Is this a Department of Labor publication?

MR. PRESLEY: Yes, it is. It's from the Department of Labor.

DR. ZIEMER: Well, first, this Board is not currently in the business of advising the Department of Labor.

MR. PRESLEY: That's exactly right.

DR. ZIEMER: Now, there are -- is there a Labor representative still here that we can refer this to and --

UNIDENTIFIED SPEAKER: I can carry that back and see if we can resolve it.

MR. PRESLEY: That was all I was asked to do was to bring it in front of the Board.

THE COURT REPORTER: Can I have your name, sir?

MR. COUCH: Yeah, my name is Jeff Couch with the Department of Labor. I'll certainly take that back and pass that word along.

DR. ZIEMER: Thank you. We appreciate that.

DR. NETON: I'd like to just ask one question, if I could. Bob, was that -- was the person seeking medical treatment for cancer, or was

it a non-cancer related illness, do you know?

MR. PRESLEY: To my knowledge, it was cancer.

DR. NETON: Okay.

MR. ELLIOTT: Do you know if this is being handled out at the Resource Centers, is that the source of this document? I mean maybe Jeff knows this question.

MR. PRESLEY: I picked this one up when we up to Los Alamos the day after our meeting in Santa Fe. They were having a -- Labor was having a conference up there or some type of a conference and I picked my copy up up there at a conference. It was being handed out, and then the one that came to me through the mail was just a Xerox copy from -- from an individual, so I presume -- I really don't know where it's been handed out, but it's been passed around.

MR. COUCH: I think that is a product of, you know, that comes out of one of our groups at the National Office.

DR. ZIEMER: Okay. Thank you. Your issue has been, in a sense, referred to the Department of Labor for resolution.

Let's move on to the Board work schedule.

The first question is: Do we have any updated information on the Special Exposure Cohort proposed ruling?

MR. KATZ: Hi, so this is Ted Katz.

DR. ZIEMER: Walk us through where we're at. Ted Katz of Centers for Disease Control.

MR. KATZ: People are working furiously to try to get the NPRM published. And based on that, there's a -- you know, there's a reasonable chance we could -- we could have this meeting on either the 27th and 28th of February -- yeah, it's a -- those are narrow windows here because there are other conflicts too. Another possibility is a one-day meeting, which would just focus, I guess, entirely on this Rule, but March 3rd or March 7th are open, too. Those would be on the front end of the comment period, which is, I think, what you would prefer if, you know, if it all works out well, and this gets posted.

DR. ZIEMER: Without committing to any specific date, is there a, sort of a expected window when this is going to come out?

MR. KATZ: Well, there's -- I mean we're hoping to be able to get it published by the 24th of February. Again, it's still in review, so we could

fail that, but that's what we're shooting for.

DR. ZIEMER: Well, let me ask it in a different way. Is it likely to be out before then?

MR. KATZ: Well, again, there's no statistics to apply to this, but -- but, yes, everybody's -- everybody's working very hard to make this happen.

DR. ZIEMER: There is a long shot then.

MR. KATZ: It's -- so it's not, I wouldn't say it's a long shot, but --

DR. ANDERSON: But I wouldn't bet on it.

MR. KATZ: -- but that's what we're -- no, no, that's -- I mean that's what we're shooting for is all I can tell you really. It's not going to go that far.

DR. MELIUS: If they're shooting for February 24th, and given -- I mean I would hate to set up a meeting for the end of that week, assuming it would be out. It seems to me that the 7th is -- that may -- I'm not sure how the availability is, but that would be more reasonable and would be within the 30-day comment period.

MR. KATZ: The 24th is giving us a little bit of a safety margin, so --

DR. MELIUS: Three days of safety margin.

MR. KATZ: No, no, no. I'm saying it could get published before the 24th, but that's got a little bit of a safety margin in it already. Again, there's problems with availability is why I'm giving you these dates. There's -- the following week, the week of the 13th is out because I believe Larry is out of pocket that week.

MS. ROESSLER: What month are we in?

DR. ZIEMER: March.

MR. KATZ: March. The week of March 13th.

MS. ROESSLER: There's no week of March --

MR. ELLIOTT: March 10th.

MR. KATZ: March 13th is in the middle of the week. Sorry.

MS. ROESSLER: The week in which March 13th occurs.

DR. ZIEMER: Well, as a starter, let's identify -- it seems to me it's unlikely that we're going to want to meet in February again; here we are into the first week in February.

MS. ROESSLER: Oh, but it's so much fun.

MR. ESPINOSA: Are we looking at just a one-day meeting?

MS. MUNN: Maybe two. It depends on what we get.

MR. PRESLEY: What I would propose, if we can come in here on the 5th through the 6th, the working committee could come in a couple of days early. Would y'all want to meet in Cincinnati?

MR. ELLIOTT: We would want to do this in Cincinnati or in D.C.

MR. PRESLEY: If we did it in Cincinnati the working group could come on in early and we could -- we could -- if everybody is available that week.

DR. ZIEMER: Well, it's a possibility, just --

DR. MELIUS: One thought I had was, and it may help with some of this flexibility is that the Chair appoint a working group to prepare some draft comments on the SEC regs, you know, contingent on timing and so forth, so --

DR. ZIEMER: And bring that to the Board, and then --

DR. MELIUS: Bring that to the Board, so, you know, that would, I think, be more practical to do the review and prepare our remarks within the one-day, you know, time limit, and so forth and not have to extend it over two days. I think it would help the process anyway. I think we can get better closure when we're there in person, rather than

doing it as follow-up conference calls later.

DR. ZIEMER: Other comments?

(No response.)

DR. ZIEMER: We can certainly do that, but let's see what availability of dates are. Let me begin in March. The week of March 3rd, who has conflicts besides the Chair?

MS. MUNN: I have a Tuesday conflict, but I could, if we had to.

DR. ZIEMER: I'm out of the loop Monday through Thursday, so I could meet on Friday.

MR. DeHART: I can meet on Friday.

DR. ANDERSON: Friday is okay.

DR. ZIEMER: The 7th is available? Okay. That's an available date. Let's look at the next week.

DR. ANDERSON: Are you saying no, Gen?

MS. ROESSLER: It's kind of difficult, but I could do it.

DR. ZIEMER: Okay. One possible.

MS. ROESSLER: I might have to quit my regular job.

DR. ZIEMER: Minor details.

MR. GRIFFON: Are we -- have we excluded February 27th and 28th?

MS. ROESSLER: No.
DR. ZIEMER: Well --
MR. GRIFFON: Those dates are actually better for me.
MR. ESPINOSA: Yeah.
MS. MUNN: Yeah, they're good for me.
MS. ROESSLER: I can't make it that week.
MR. DeHART: I can't either.
DR. ANDERSON: I can't either.
DR. ZIEMER: I guess we've excluded. Okay. The week of March 10th, any bad dates there?
MR. ELLIOTT: I can't do it.
MR. GRIFFON: I can't do it.
DR. ZIEMER: The whole week is out.
MR. ELLIOTT: I need a vacation.
DR. ZIEMER: The week of March 17th. The week of March 17th, who has got conflicts the week of March 17th?
MS. MUNN: Monday, Tuesday's okay, Thursday, Friday's okay.
DR. ANDERSON: Friday's out.
DR. ZIEMER: Bad days. Okay. The 21st is out. Others?
DR. MELIUS: The 20th is out.
DR. ZIEMER: The 20th is out.

MR. ELLIOTT: Now you're at the last week of Public Comment Period.

MS. ROESSLER: 17 and 18, is that available?

DR. ZIEMER: We're at the last of the Public Comment Period if, in fact, it is out in time.

MS. ROESSLER: 17 and 18 possible? No.

DR. ZIEMER: Okay. Do you want to settle on a specific one of these dates? Are we talking about one day then?

MR. PRESLEY: I would think.

DR. ZIEMER: One day in Cincinnati.

MS. ROESSLER: How about if the working group gets together the 17th and/or the 18th, and then the Board meets on the 19th for just a one-day meeting if we do what Jim suggested about having another group do a preliminary on it?

MR. GRIFFON: The only concern I would have is if there is significant changes to the SEC rules, which I imagine there are, we don't leave ourselves any follow-up time; we're right at the end of the 30 days.

MS. ROESSLER: Yeah, that's nervous.

DR. ZIEMER: Which then pushes us back to approximately the 7th.

DR. MELIUS: What about the working group on

Thursday?

MR. GRIFFON: I'm not sure I can.

MS. ROESSLER: I'll just have to make it work.

MR. GRIFFON: Yeah, the working group -- I mean I would like to link it so that the working group could go up maybe Thursday, or Wednesday and Thursday, you know, or at least -- at least Thursday.

MR. DeHART: Okay.

MR. ESPINOSA: That week is a little bit rough, but if we can pinpoint it to where I know in advance. I mean is it going to be two days for the working group and then a day with the Advisory Board?

MR. GRIFFON: I would say just Thursday.

MR. ESPINOSA: Just Thursday?

MR. GRIFFON: Yeah.

MR. ESPINOSA: Because you've got to consider a day of travel going to, and that kind of throws me off if we're going to go the Wednesday and Thursday.

MR. GRIFFON: I'm just a little nervous about just giving ourselves one day. We have a pretty large scope of work for the working group

also, and --

DR. ZIEMER: Well, and also keep in mind that we also still have a meeting in April scheduled, and --

MR. GRIFFON: Yeah, there's more opportunities to go back to Cincinnati.

DR. ZIEMER: I don't think when we charged the working group we were anticipating you would only have a couple of weeks to get together, so you could give us a status report, but not have necessarily completed everything.

Okay. We appear to have reached agreement that we are going to set aside March 7th, one-day meeting, Cincinnati, to deal with the Special Exposure Cohort. This is contingent on the publication in the *Federal Register* actually having occurred.

And Cori, I assume in Cincinnati it will be a situation where if we need to cancel you will need to -- well, you're --

WRITER/EDITOR: We can't hear you.

DR. ZIEMER: I was just wondering, if -- if she goes ahead and blocks off hotels and then it turns out the document is not available, how readily she can cancel, maybe not any easier in Cincinnati

than anywhere else. The same problems arise; penalties, and so on, at hotels. We'll have to deal with it.

Okay. I guess we've agreed on that.

DR. ANDERSON: Just --

DR. ZIEMER: Henry.

DR. ANDERSON: I mean will we have some advance warning of an actually firm publication date? I mean isn't there two weeks to get it into the *Federal Register* or something?

MR. KATZ: No, it actually just takes a couple of days once it's cleared by the Secretary, so.

DR. ANDERSON: Okay.

MR. KATZ: But we'll give you whatever advance notice we can.

DR. ANDERSON: Yeah, I was looking for, you know, as far as scheduling and finalizing the meeting. You're going to have to get it -- our meeting has to be notified sufficiently in advance, so we may have to put the meeting in the *Federal Register* before we know that we're even going to have a meeting, and canceling the *Federal Register* meeting becomes --

DR. ZIEMER: Now, it's been suggested that

we also have a working group to do some advance work on preparation of comments prior to the meeting. Let me ask -- that was the suggestion, let me ask if there is any sort of consensus amongst Board members that you want to have a working group do that. There seems to be a consensus.

DR. MELIUS: I think it would just be helpful to have -- somebody have some language ready. We have our prior comments.

DR. ZIEMER: Yeah, right.

DR. MELIUS: We'll see what changes there are --

DR. ZIEMER: I'm going to ask --

DR. MELIUS: -- and stuff like that.

DR. ZIEMER: -- I'm going to ask -- the Chair will ask for volunteers to be on the workgroup, a minimum of three people. Jim, Mike, okay. I will be the third person and the three of us will try to work out -- so this will be a workgroup to draft some language for the Committee as possible comments on the *Federal Register* notes.

Let me ask, does that workgroup also wish to come in to Cincinnati a day ahead, or we might be able to do this by e-mail or phone.

DR. MELIUS: By e-mail.

DR. ZIEMER: E-mail and phone, okay.

Comment?

MR. ELLIOTT: Ted, help me here. I think we can help this working group of the Board by giving them a cross-look analysis of what changes were made.

DR. ZIEMER: That would be very helpful.

MR. KATZ: Yeah, I was just assuming I would attend that working group. How about that?

DR. ZIEMER: And Ted, that might be a teleconference sort of thing. We'll get the documents and we can talk. Thank you.

DR. MELIUS: Or you can come visit one of us.

DR. ZIEMER: Mark.

MR. GRIFFON: Just a point for clarification that the dose reconstruction working group plans on meeting on the 6th, one day ahead of that meeting in Cincinnati, March 6th, so we plan on working that day on our tasks.

DR. ZIEMER: Agreed. Thank you.

Comment?

MR. NAMON: I was just going to add that it was our hope that we would have one of your attorneys for the dose working group, but on the 6th

we will not be able to do so, but we will certainly be available for other occasions to make sure that especially the privacy angles are covered.

DR. ZIEMER: Yeah, and at this point they're still going to be dealing just with procedures and so on, not -- not working on dose reconstructions per se.

MR. GRIFFON: I should ask though, Jim Neton if he could have any staff available?

DR. NETON: I should be able to.

DR. ANDERSON: Paul, do we have a drop-dead date and a fall-back? Do we want to look at the week of the 17th for a fall-back? I mean let's say the 24th isn't met, and instead it's planned to come out on the 5th, and so now we've got two days, you know, and what -- what kind of lead time does one on the workgroup to be able to read -- I guess I don't us to have a one-day meeting and have those of us who were out the previous week not have any chance to take a look at it, so, you know, I just don't want us to all get together and now we'll have another gripe session about how here we are again without insufficient time, so we probably now ought to plan our strategy that if it doesn't come out --

DR. ZIEMER: What is Plan B?

DR. ANDERSON: Yeah, what's Plan B, if it isn't on the 24th, do we then go to the fall-back period? It's too bad if we have to cancel rooms and there's a cost, but to have a meeting with insufficient time, you know, and not waste our time too.

DR. ZIEMER: Good point. Jim, you have a comment?

DR. MELIUS: Yeah, I was going to say the contingency may be a little bit more complicated, but I think we pick one day because it's going to depend on when it comes out, and --

DR. ANDERSON: Yeah.

DR. MELIUS: -- that we pick one day that could either be an alternative meeting day, or an alternative date for a conference call if we, you know, can prepare preliminary comments we need to finish at the 7th, but, you know, we're able to finish them up later or whatever, so.

DR. ZIEMER: Good suggestion.

DR. ANDERSON: I mean what we -- we don't know how --

DR. ZIEMER: There has to be a reason.

DR. ANDERSON: -- how extensive the changes are and then how -- how much conversation and

concern will be raised by those changes. If there's changes that basically reflect our advice on the first set, we shouldn't have as much of a problem with doing it.

DR. ZIEMER: How about if we pick a time, a day in the week of the 17th, that could either be used for a full meeting, if needed, or for a conference call meeting.

DR. ANDERSON: Yeah.

DR. ZIEMER: What were the conflicts that week?

DR. ANDERSON: Just Friday, I think.

DR. MELIUS: I have a conflict on Thursday.

DR. ZIEMER: 20th and 21st were out; 17th, 18th, or 19th, that's Monday, Tuesday, or Wednesday. Any preferences?

MR. GRIFFON: Well, how about the 18th, if that's possible for people cause then we could have the working group --

DR. ZIEMER: Because then you still --

MR. GRIFFON: -- meet on the 17th, if --

DR. ZIEMER: -- have your working group.

MR. GRIFFON: -- that's a good day for the working group, as well.

DR. ZIEMER: So we'll mark -- is that

agreeable with everybody? We'll mark as Plan B, the fall-back date would be March 18th with the working group meeting on the 17th, or the Dose Reconstruction Review Workgroup.

Okay. Thank you.

Let me ask, Cori, do we have other housekeeping items?

MS. HOMER: Just a couple.

DR. ZIEMER: Yes.

MS. HOMER: If you want to turn to the last page of your Minutes where the action items are listed. There were four listed; bullet one and bullet three were actually taken care of today: Providing the Board with a list of sites lagging in responding to records requests and a breakdown of reasons why; and, an update on implementation of the conflict of interest policies was requested. And I believe both of those have been handled during this meeting. The last one was just a projected meeting dates and we've already taken care of that.

Just as an update, I have not signed a contract, but have pending dates in Oak Ridge for April 28th and 29th, and will get back with you as soon as possible as soon as those dates are confirmed with the hotel.

MR. ELLIOTT: What the Board needs to decide is, you know, are those -- do they want to meet again on those dates, I think.

MS. HOMER: Okay.

MR. ELLIOTT: And now is the time to figure out if, you know, if you're going to meet in April and, you know, what do you -- I mean we talked about some IREP scientific issues that we might be able to explore a little bit, but what would your agenda look like, I guess.

DR. ZIEMER: Well, particularly if we meet in March on the Special Exposure Cohort.

DR. MELIUS: I was --

DR. ZIEMER: Well, the other -- the other thing that we would be far along on the -- on this issue and so I guess it would be the review procedures issues, task order, and the selection.

DR. MELIUS: I don't know if, on some of those IREP scientific issues, whether it will be timely to -- if that will give you enough time to prepare one of those or something.

MR. ELLIOTT: I think the end of April.

DR. ZIEMER: Yeah, this is basically the end of April.

MR. ELLIOTT: I think HERB could be ready,

that's the research branch at NIOSH, and I think they can be ready by April to give you a presentation on the status of DOE workforce studies.

DR. MELIUS: Maybe start on the smoking thing or something, I don't know, just see where you, how it would work out.

DR. ZIEMER: Okay.

MS. MUNN: I guess I need to whine and carry on a little bit about that April date. At the time we were talking about them I did not realize that I would be in China for the preceding two weeks, and --

DR. ZIEMER: This is prior to the Oak Ridge?

MS. MUNN: Prior to the Oak Ridge meeting, yeah. The earliest date I could be back from China would be Sunday, the 27th, and probably Monday, the 28th, which means I have a choice of stopping on the West Coast and changing my clothes, or just continuing to fly to the East Coast. And I'm not at all sure whether I'd be awake at all while we were here. If there's --

DR. ANDERSON: We can handle the medication side.

MS. MUNN: Thanks. Thanks a lot. Yeah, I appreciate that part. Do I get go-pills or no-go-

pills?

DR. ANDERSON: I've got some military contacts.

MS. MUNN: Yeah, yeah, if the Air Force can do it, then I can do it. I guess the -- the 1st and 2nd would be so much better for me if it's at all possible to do that.

DR. ZIEMER: Well, the 1st and 2nd were the alternative dates.

MS. MUNN: Okay.

DR. ZIEMER: In the meanwhile, Cori, did you already check, are we locked into April?

MS. HOMER: We are not locked in.

DR. ZIEMER: Are the other two dates available, or?

MS. HOMER: Those are the only two dates available at the hotel in Oak Ridge; Knoxville, I'm still searching.

DR. ZIEMER: I certainly don't object to waiting till Thursday and Friday. We can still go into Oak Ridge, right, without having -- we don't need to stay in an Oak Ridge hotel necessarily.

MR. DeHART: I won't be able to be there on the 1st and 2nd.

MS. MUNN: Roy.

DR. ZIEMER: Was there a reason we excluded the 30th? For example, suppose it was the 29th and 30th, or the 30th and the 1st.

MS. MUNN: The 30th and 1st I could do.

DR. ZIEMER: Did somebody have a conflict?

DR. MELIUS: I have a conflict on the 30th.

DR. ZIEMER: That was the problem. Well, the other thing is recognizing we were trying to keep this sort of early in May because there was a big gap between this meeting and then, but we have another meeting in between, so we could go later in May if we needed to. There would be no reason we couldn't do that. It might even be nicer in Oak Ridge.

What is your pleasure?

MS. MUNN: The following week is --

DR. ZIEMER: I see no urgency to meet early May if we have another meeting next month anyway.

MS. MUNN: The following week is good for me.

DR. ZIEMER: How is the following week?

And we're not locked in, you said?

MS. HOMER: No, we're not.

DR. ZIEMER: How is the week of May 5th?

MR. DeHART: I'm out.

DR. ZIEMER: Out all week?

MR. DeHART: Yeah.

MR. ESPINOSA: Are you out the whole month, or?

MR. DeHART: What?

MR. ESPINOSA: You were saying something about being out a whole month.

MR. DeHART: No. That was April. I'll be in China with her. Keep it quiet.

DR. MELIUS: We'll meet there.

MS. MUNN: Yeah, okay. Fine.

DR. MELIUS: Larry won't invite us to the beach, maybe you two could invite us to China.

DR. ZIEMER: How about the week -- how is the week of the 12th?

MR. ELLIOTT: I can't do that.

DR. ANDERSON: Okay.

MR. GRIFFON: I think the only -- I was going to say the only thing I'm a little concerned about is if we start moving too far back, if we get this -- which we hope we will get this contract out, the clock, if I remember right, is 120 days, and that will be like June -- mid June, and I'd like to have these task orders like ready to go.

DR. ZIEMER: Yeah, ready to go.

MR. GRIFFON: Right, so just keep that in mind.

MS. MUNN: So you said you couldn't make the 1st. Could you make the 2nd?

MR. DeHART: No.

MS. MUNN: You're out the 1st and 2nd. Okay. You can have your choice; you can have me, or you can have Roy. Take a toss up.

DR. ZIEMER: This is a tough one. How many favor Roy?

(Laughter.)

MS. MUNN: All in favor of Roy, all in favor of Wanda?

DR. ANDERSON: A sleepy Wanda, or an absent Roy.

DR. ZIEMER: Yeah, I don't like to look at it that way?

MS. ROESSLER: What was wrong with the week of the 5th, again?

DR. ZIEMER: That was out for --

MS. ROESSLER: Who?

DR. ZIEMER: Roy. And the week of the 12th is out for Larry. And is the week of the 19th actually too late you think, Mark?

DR. ANDERSON: We've already marked that as

a follow-up. That was a --

DR. ZIEMER: May.

MR. ELLIOTT: Yeah, we did. We already marked that as May 19th and 20th was also acceptable.

DR. ANDERSON: But that was for conference calls.

DR. ZIEMER: No, that was the regular meeting time.

MS. MUNN: That was a regular meeting, yeah.

DR. MELIUS: February 19th was the conference call.

DR. ANDERSON: Okay.

DR. ZIEMER: I'm wondering, are we still okay, I hate to meet with people having to be absent.

MS. MUNN: Yeah, I do too. The 19th and 20th is fine for me.

DR. ZIEMER: Any objection to May 19th and 20th?

DR. ANDERSON: Where would it be?

DR. ZIEMER: Oak Ridge, I think.

MR. PRESLEY: Oak Ridge.

DR. ANDERSON: Because I have to be in San Diego on the 21st.

MS. MUNN: That's easy. Easy. It's a long day, and you're going to a major hub. Don't worry about it.

DR. ANDERSON: Well, I just need to get out on the afternoon of the 20th, so if we end on the 20th at noon, I'm okay.

MS. MUNN: Yeah, you're going West, just stay up all night.

DR. ANDERSON: Thanks a lot.

DR. ZIEMER: Okay. It appears that we have consensus for May 19th and 20th for our Oak Ridge meeting, as opposed to the May 1st. That's only a two-week delay, so maybe we'll be okay.

Thank you. Any other housekeeping items then, Cori?

MS. HOMER: Just provide Larry with your written outside hours if you've worked on a working group, or prep time. Please be as specific as possible, so that I can submit the request accurately.

One other thing, because I haven't requested this in a while. Take a look at the roster and check your information; make sure it's all correct, and if I need to update it, please let me know as soon as possible.

DR. ZIEMER: Now, the only task we have left to do is to address the proposed changes in Section -- or Attachment A, and it's going to be a little while before the -- the computers or printers here has a virus I understand and they actually had to send this out. I was hoping we could simply work through and finish before lunch, but it looks like we'll take a lunch break, and deal with that immediately after lunch.

MR. GRIFFON: I can scroll through it.

DR. ZIEMER: I'll leave it up to the group, but --

MS. ROESSLER: I'd like a printed copy if we can get it.

MS. MUNN: It makes it a lot easier.

DR. ZIEMER: We all have to eat lunch anyway, so.

MS. MUNN: Yeah.

DR. ZIEMER: Let's do that and take a break. Let's try to be back here as close to 1:00 as we can; if you're here by 1:00 we'll start, and finish up -- certainly finish up before 2:00 o'clock, maybe sooner.

(Whereupon, a luncheon recess was taken.)

BY DR. ZIEMER: (Resuming)

I'm going to ask Robert Presley to quickly determine the level of interest for the Oak Ridge meeting in a tour of ORNL and K-25.

MR. PRESLEY: Would anybody be interested in taking -- when we go to Oak Ridge, taking a two-, two-and-a-half-hour tour of the second -- the last half of the second day? And what we will do is get permission to go over to ORNL; drive through; talk a little bit about what went on; and Larry's mentioned going to the graphite reactor; we're going to get permission to do that; go to K-25; drive through; let you see the buildings; talk about what went on at K-25; come back over to Y-12; go up on the Ridge, the Overlook at Y-12; and talk about what went on in some of the buildings at Y-12. That's -- you're talking about two, two-and-a-half hours.

DR. ZIEMER: Can we see a level of interest? How many would want to do that if we can arrange it?

BOARD MEMBERS: (Board Members raise hands.)

MS. MUNN: I guess that sounds like a few.

MS. ROESSLER: In the audience, too.

MR. PRESLEY: The public, sorry, it will only be Board members.

MS. DiMUZIO: Staff also?

MR. PRESLEY: Staff -- yes, staff can go.

DR. ZIEMER: Okay.

MR. PRESLEY: All right. We're talking about 20 people, so we'll need a bus to hold 20 people.

MS. MUNN: Yeah, we're talking about a little bus.

MR. PRESLEY: I'll try to set that up.

DR. ZIEMER: Now, the item we have before us is Attachment A. And Mark and the working group met during the lunch hour to give us some level of assurance that the working group has agreed to the changes. And Mark will lead us through these items and show us where there's no change. As an example, the first three items appear in the current contract, or the current Attachment A, but he's moved them from other locations. So lead us through and show us what the changes are, and I would say most of the document, there's no wording changes either, but we have some that are perhaps critical here, so Mark, take us through very quickly, starting at the beginning there.

MR. GRIFFON: I can say that I'll go through the new document and then we get to Section E, I've opened the old document up and I've numbered the

paragraphs there and I can show you where we kind of cut and pasted because things got moved around; a lot of the language is very similar, but things got moved around and it would be hard to do a side-by-side, so I'll take you through Section E separately. But first, looking at the overall document, like Paul said, the first three items were moved to the front end and it's both the areas where points are assigned, you'll notice, and that was because these are more or less hard-line criteria; if they don't meet these prerequisites, if the bidders don't meet these prerequisites, they can't bid on this contract, so we thought they needed to be pulled out of the point system and into the front part of the document. So this is the one that's been handed out, Wanda, is that -- is everyone looking at the one that just got handed around? Okay.

Section A, if you --

DR. ZIEMER: Just as a matter of interest, the first item in the old contract --

MR. GRIFFON: Well, I was going to --

DR. ZIEMER: Okay.

MR. GRIFFON: I'm going to do that later, let's step through the whole document first, then I'll go back to that, yeah.

DR. NETON: Excuse me, one second. What file was that on here?

MR. GRIFFON: It's Attachment A, underscore 5.

DR. NETON: The last one in that group?

MR. GRIFFON: Yeah. Yeah, that's it, the last one.

If you look at Section A, Personnel, in this new document -- they're going to hand it around -- it's all the same, to the best of my knowledge. I haven't done a word-by-word through it, but I think the only section that we edited was Section E, actually; so Section B is the same; C is the same; D is the same; E is drastically changed, but a lot of the paragraphs were cut and pasted, but they were modified somewhat, so we should step through that; and then Section F remains the same.

So now if you -- if you could open the old document that's in our binders, if you look, for instance, at the first paragraph E-1, I labeled that E-1, the first paragraph in the old document, that ends up being in the new document under the Conflict of Interest Plan section, the 10-point section, the first paragraph there. The language is not the same, but the concept is the, you know, that's where

that concept moved to.

DR. ZIEMER: Which paragraph is that?

MR. GRIFFON: It's the second paragraph, the first paragraph under the Conflict of Interest Plan on the new.

DR. ANDERSON: Where it says Conflict of Interest Plan, 10 points?

MR. GRIFFON: Right. And this -- I should step back a second -- the section is divided up into two sections; Conflict of Interest Plan, 10 points, and Work History, 15 points, and the bullets that sort of fall into each, that's why there was some cutting and pasting from the previous document because they weren't always in the appropriate order, so we moved them around a little. And this Plan is what -- basically what we're expecting. They're not disqualifiers, it's that this is the information that you should include in your plan, a minimum to disclose potential, perceived, actual Conflicts of Interest on -- on your team. And then the Work History below, is actually -- there will be 15 points assigned, paying attention to the key personnel staff, and organizational conflicts of interest; and it goes on, but the one striking difference in that section is that previously we had

a hard-line where we said if the bidders worked -- the bidders were key personnel and worked with DOE, DOE contractors, etcetera, etcetera, or NIOSH, or ORAU within the last two years they were disqualified. Well, we -- we took that out and we replaced it with the phrase about that greater emphasis will be placed on the work history within the past two years -- work experience within the past two years; so again, that gives the panel more flexibility, and points will be assigned based on this, but it's not, they're not disqualifiers anymore, like they were in the previous document. That was the idea, to give --

MS. MUNN: That's good.

MR. GRIFFON: Yeah. Part of the reason this arose was the concern that we would be excluding too many potential bidders, and yeah, unintentionally, but -- but it would have happened probably, so. So then if -- if we brought -- let's see, let's start at the front end of this document, the front end of the new one. If you want to do a paragraph-by-paragraph, these three points that I listed there as prerequisites now, used to be in the -- the first one was Section E of the old document, paragraph number 6, which is on page 10.

MS. ROESSLER: Under number one, I think the intent was here to eliminate anybody who's working for NIOSH. And then as far as ORAU goes, that's the part of ORAU under the contract -- Dose Reconstruction Contract, that doesn't mean all of ORAU, does it? Back in the document it does put in parentheses under Contract Number 200-so-and-so, or does that -- is the intent there that nobody who works for ORAU?

MR. GRIFFON: The intent was any work for ORAU. If you look back at the part of E-6, it doesn't have that reference to the contract. That's for another.

MS. ROESSLER: Okay. So anyone who's currently, or in the past -- well, currently working for ORAU, which is a really big group, is automatically eliminated.

MS. MUNN: For key personnel.

MR. GRIFFON: Right.

MS. ROESSLER: Yeah, I mean I just want to make sure that that was the intent.

MR. GRIFFON: Yeah.

MS. ROESSLER: I don't know that that's bad, but I --

MR. GRIFFON: That's the intent.

MS. ROESSLER: Okay.

MR. GRIFFON: I think we -- we did have some debate on that, but that's, if you look at E-6 in the original document --

DR. ZIEMER: It's the same words.

MR. GRIFFON: -- that's the same words. Yeah. And you'll notice Paragraph E-6 of the original document was split in half, and the reason for that, if you look when we get back to Section E, is that we didn't want that hard-line of a criteria for DOE or DOE sites, DOE contractors, but we still thought the bright line should apply to NIOSH and ORAU because it just -- this was too close to what they'd be doing under this contract, and so we give more flexibility, and if we look in Section E you'll see that. And the idea there was that they may have other work, and they'd be evaluated based on that, so that if their other work with DOE was really closely related to dose reconstruction, I think that will work against them, as opposed to if they had other work with DOE that wasn't in any way related to dose reconstruction, I think you'd say that, you know, that's fine, so. So the second paragraph on the top of the document there comes from Paragraph E-4 in the original document.

DR. ZIEMER: The only change is the word "additionally" in the original document.

MR. GRIFFON: Right. This is the expert witness question that we've gone through.

And then the third paragraph is the one that Gen, that you were talking about. This says -- I think, maybe I'm wrong -- but this says that anyone that's under the current NIOSH contract obviously can't also be on the auditing contract.

MS. ROESSLER: Okay. So the first one is broad, and the third one is specific.

MR. GRIFFON: Right.

DR. ZIEMER: And again, this is the same wording as before, the only exception being that the original paragraph had the word "finally" --

MR. GRIFFON: Right.

DR. ZIEMER: -- at the beginning of it, which is not needed.

WRITER/EDITOR: Say that word again.

DR. ZIEMER: For the third point, finally. The original document had the word "finally" at the beginning because of the way it was sequenced in here. It's just item three. But that doesn't change the meaning in any way.

MR. GRIFFON: Then going on to Section E

itself, the first paragraph, as far as I can tell on my quick cross walk here, is a new paragraph. And that was just to put the overall goal or objective of this -- this Conflict of Interest section in perspective. I think a key phrase here at the end of this is that, you know, the Board's statutory dose reconstruction review mandate in order to assure the highest degree of independence, while balancing these concerns with technical qualifications. So this is the idea, just to put the rest of this section into perspective. We're looking for balance between technical qualifications and conflict of interest issues.

And under Conflict of Interest Plan, the 10-point section, that first paragraph comes from E-1 in the original document. Okay. And it looks longer, so I'm assuming it was modified a little bit. It generally talks about disclosure of your personnel basically, and what their potential, perceived, or actual conflicts would be. And this is the plan itself. Okay.

Stop me when it's appropriate.

The next paragraph comes from --

DR. ZIEMER: Mark?

MR. GRIFFON: Uh-huh (affirmative).

DR. ZIEMER: Let me insert here. The first part of that, I guess it's the first couple of sentences are the same or similar, but then this is expanded from before, including this: The entire plan shall be made public.

But doesn't that parallel what we had on, or what ORAU had in their requirement?

MR. GRIFFON: I thought it did, yeah.

MR. NETON: I don't think we committed to making the plan public, but we did.

DR. MELIUS: Yeah, I think that's --

DR. NETON: I don't think the contract requires specifically that we make the Conflict of Interest plan public.

MR. GRIFFON: That's actually in the -- in the original E-1 paragraph, isn't it?

DR. NETON: I don't think so.

MR. GRIFFON: E-1 in the -- in the last draft that we did.

MR. DeHART: Yes.

DR. ZIEMER: Well, and incidentally, that last sentence of that paragraph, Mark, is somewhat similar to the second to last paragraph at the end of the document, which says something about what we plan to do in the future; it's not a grading or an

evaluation. You're sort of telling the contractor that, oh, by the way, we can make this information public, so it would seem to me that as an option we might suggest the contracting officer, if there's another place in the contract to put that, it could be moved; it's certainly not part of the evaluation screen itself.

DR. MELIUS: Though I think -- I agree with that, though I think it also, to me it would be helpful if I was applying for this to know, understand that oh, I have to do a, you know, a conflict of interest, and by the way, it's going to be a public record.

DR. ZIEMER: Right. I'm saying it -- it could be in another part of the document, not in the evaluation criteria --

DR. MELIUS: Right.

DR. ZIEMER: -- we're not evaluating them on that.

MR. GRIFFON: Agreed. Agreed.

DR. NETON: It might be the case, though, that someone would not want to have their conflict of interest plan public, and in which case they could be docked under this criteria.

DR. ZIEMER: Good point, but we're not

leaving that as an option, are we?

DR. NETON: No.

MR. GRIFFON: Right. That's why it may be --

DR. NETON: We could put it in both places, I suppose.

MR. GRIFFON: Maybe it can be -- yeah, I don't object to it being moved to the main body or something like that.

DR. ZIEMER: I think we can leave it in here now, but I'm just saying it's -- we're not evaluating per se on that basis.

MR. GRIFFON: Yeah.

The next paragraph was the former paragraph E-5. I think that's very close to the original language, except that NIOSH and ORAU are removed from that because that's a hard-line at the front of the document now, the NIOSH and ORAU --

DR. ZIEMER: They're already --

MR. GRIFFON: Right. That's a hard-line, so you don't lose -- right.

The next paragraph is from the original document, paragraph E-6, it's the other half -- remember I said E-6 was split in two pieces -- this is the other section, not related to NIOSH and ORAU,

but related to DOE and AWE, and this allows that they can pursue other radiation-related work with DOE or DOE contractors, but they should demonstrate how this will not affect their performance on this contract, and their potential conflicts related to this contract.

DR. ZIEMER: Mark, let me back you up one minute. That paragraph we just covered is talking about past work, I think, and the -- the hard-line elimination in 1, 2, and 3 at the front of the document, I believe only refers to current work with ORAU and its team partners. Doesn't this paragraph refer to past work with DOE, AWE, and therefore could also include ORAU and the team partners?

MR. GRIFFON: I think you're right. I think --

DR. ZIEMER: It seems to me the original document which included them was probably correct.

MR. GRIFFON: Yeah, I might have over edited here. I think you're right.

DR. ZIEMER: As I look at those two side-by-side, I'm suggesting that we put the words back to the way they were in the original document, which includes both NIOSH and ORAU, ORAU teaming partners because it's -- it's talking about past, not current

activities. Am I correct on that?

MR. GRIFFON: The only thing I reflect on is it's talking about --

DR. ZIEMER: It says at any time in the past.

MR. GRIFFON: -- it's talking about will not perform reviews related to that site. And NIOSH and ORAU are not sites, right? Maybe that's why I edited it. I think that's why we changed it. I'm doing this on the fly here, too.

DR. NETON: This is just related reviews --

MR. GRIFFON: Right.

DR. NETON: -- conflict -- conflicted at that site.

MR. GRIFFON: So it's similar to ORAU's policy where they, anyone from their team who worked -- formerly worked at a site will not be involved in the -- will not be the reviewer on that, on those sites. So I think the new version is more correct.

DR. NETON: I think so.

MR. GRIFFON: Yeah.

DR. ZIEMER: So in that case, ORAU personnel could have been a DOE contractor at a site and that's what it covers in here.

DR. NETON: Right.

MR. GRIFFON: Yeah. Yeah.

So the next -- the next paragraph was -- was the other half of E-6 in the old document. And this allows just what I said before -- I know this gets confusing because we jump around -- this allows for bidders to also pursue other work with DOE, but they should explain in the plan how this is not going to affect their performance on this contract, or their independence.

MR. DeHART: Mark, would you read the first few words of the first -- of that paragraph so I make sure I'm in the right spot?

MR. GRIFFON: Yeah. E-6 is -- it starts off with: The offeror, teaming partners --

MR. DeHART: Yeah, teaming partners.

MR. GRIFFON: -- and key personnel.

MR. DeHART: Now, where are you reading right now, the same line, right below work history?

MR. ELLIOTT: You're talking about the new document?

MR. DeHART: On the new document.

MR. GRIFFON: Oh, in the new document. It's the third paragraph under Conflict of Interest Plan.

MR. DeHART: Okay. I see.

DR. ZIEMER: In addition, it says.

MR. DeHART: Yeah, I've got it.

MR. GRIFFON: All right. The Work History, the first paragraph in the new document, relates back to Paragraph E-2 in the original document. And again, the key here is that, you know, we had the hard-line test in the original document where if they have worked in the past two years at all, they were excluded, and now we -- we rephrase that down halfway, about halfway through the paragraph it says: Greater emphasis will be placed on work experience within the past two years, including current contract relationships.

So we're -- we're considering it and it's going to be part of the review and the evaluation scheme, but they're not excluded if they worked with them in the past two years.

And the next paragraph --

DR. ZIEMER: Mark, I'd like to ask a question. As I looked at the words here, in the old document you talked about the needs justification; in this one we talked about a justification. It did not occur to me, is there a difference, or is that the same thing? Is there such a thing? Do the words mean anything different, that's all I'm asking, "needs justification"?

MR. GRIFFON: I didn't think so. I thought justification just was more accurate.

DR. ZIEMER: It's certainly encompassing.

MR. GRIFFON: Yeah.

DR. ZIEMER: I wasn't sure. Okay. I'm happy with that. I just wanted to make sure.

MR. GRIFFON: The next paragraph is from the original document Paragraph E-3, and this does similar -- it does a similar thing for previous work with NIOSH and ORAU, stating that a greater emphasis will be placed on the last two -- experience within the past two years, the same kind of criteria, but that there's no exclusion -- excuse me, there's no exclusion principle.

And then the last item there, key personnel. This whole -- the last two paragraphs here came from the original document in Paragraph E-9, and you'll see that I -- I stripped out the bigger portion of this paragraph and put a header on it saying: Limitations on Changing Key Personnel, moved to the body of the contract. That was sort of a question for us to consider, similar to the point that Paul just raised. All of that paragraph there is important, but we don't think it's really criteria which we can evaluate against. It's the limitations

going forward for the bidder that they should be aware of about changing personnel.

DR. ZIEMER: So that might be moved to a different part of the contract --

MR. GRIFFON: Right.

DR. ZIEMER: -- as an information item.

MR. GRIFFON: And I think Larry -- if I'm not wrong, I think Larry said that that possibly could be added to the body of the -- the task order contract.

DR. NETON: Could you define what you mean by diversion, you just mean change of personnel, or replacement of personnel? That sounds --

MR. GRIFFON: Where?

DR. NETON: At the second sentence: No diversion shall be made by the contractor, blah, blah, blah.

MR. GRIFFON: I don't know. I thought this -- I actually thought we lifted this language from the ORAU/NIOSH agreement. Maybe I -- maybe I edited it.

DR. MELIUS: It sounds like contracting language.

MS. ROESSLER: It sure does. I don't understand --

MS. MUNN: Yeah, whatever that means.

MR. GRIFFON: Yeah, I rarely use the words ratify too, so.

DR. NETON: Yeah.

DR. ZIEMER: If it's agreeable, something like that, or we think we are following contract language, if it's the wrong words maybe we could allow the freedom to edit that.

MR. ELLIOTT: The contracting officer would be the one to move this to the right place in the body of the RFP, and evaluate that language as to is it saying the right thing according to the FAR, so.

DR. ZIEMER: Mark, could I ask you now to move the adoption of these changes, and then we'll get it on the floor.

MR. GRIFFON: Okay. Yeah, I'd like to make a motion that we move to accept these amendments of Attachment A.

DR. ZIEMER: Seconded?

MS. ROESSLER: I second.

MR. DeHART: Second.

WRITER/EDITOR: I'm sorry. Who seconded?

DR. ZIEMER: Gen, or --

MS. ROESSLER: I'd like to second it.

DR. ZIEMER: We have two seconds here.

MS. ROESSLER: Roy likes to second it, too.

DR. ZIEMER: Now we'll open the floor for discussion. I did commit to Mike Gibson, who had to leave, to relay to the group that Mike has reviewed this and he is in agreement with the proposed changes, and I told him I would pass that along to the Board.

Okay. Other comments? Yeah, Jim.

DR. MELIUS: I would just, again, probably going back to our last meeting, speak certainly in favor of these. I think that it's sort of recognizing that people may have what we call minor relationships, and I think someone used the example the lectureship, or being paid for a lectureship through ORAU, or a travel contract, or something like travel arrangements or something like that, similar arrangements I can imagine with NIOSH and so forth, so it certainly would open it up and I think be much fairer in that way. There's, I guess a certain amount of risk involved in a sense that it would allow more balancing this versus technical qualifications, and -- but I think that risk is worth -- worth taking if it will help us to get a better pool of bidders for this process.

DR. ZIEMER: It certainly makes it more

flexible, does it not?

DR. MELIUS: Yeah.

DR. ZIEMER: Now, we'll have whatever additional discussion is needed. We can -- we can vote on this as a document unless people want to look at specific sections and make changes in what's been proposed, in which case we can go back and -- and modify, and then complete those modifications, and then adopt the document with whatever additional modifications there may -- so if anyone wishes to address or propose changes to what Mark has presented, this would be the time to do it.

I'd like -- is Dave still here? I just want to find out if they had a chance to review this. Were there anything that jumped out that sort of -- the whole document just jumps right out.

MR. NAMON: Based on the five minutes we've had to look at it, the only thing that jumped out at me was something that Jim already mentioned, was the word "diversion", which I gathered no one really knows why it's there. But I also gather it means, in this case, it was talking about change in the personnel.

DR. ZIEMER: Yeah, we think we know what the intent is there, so if it's not the right word,

well, we'll --

MR. NAMON: I'm not really in a position to tell you, you know --

DR. ZIEMER: Or if there was anything that jumped out because I know you had a chance to look through it -- or any of the other staff, who...

The real thrust of the changes -- the real thrust is the issue of the two years.

MR. GRIFFON: (Nods head affirmatively.)

DR. ZIEMER: That's sort of the bottom line, going from the sharp-line two years to the flexible two years.

MR. NAMON: There was one more question, which is under the first paragraph under Conflict of Interest plan.

DR. ZIEMER: In the new document?

MR. NAMON: In the new document. The second sentence: This includes, but is not limited to, a detailed current and past history of the offerors contracts and financial relationships.

And the financial relationships seems to be the new concept that wasn't in the previous document. I didn't know what the thinking was there.

DR. ZIEMER: Mark --

MR. GRIFFON: That's -- yeah.

DR. ZIEMER: -- can you clarify that?

MR. GRIFFON: New language, just thought it was more comprehensive. That's true, that is the new language.

DR. ZIEMER: And again, I suppose that if there is some sort of legal limitation contractually that doesn't allow collection of certain kinds of financial information, obviously that could be reworded, right?

MR. GRIFFON: Yeah.

DR. ZIEMER: This is sort of an intent at this point?

MR. GRIFFON: Yeah.

DR. ZIEMER: Larry.

MR. ELLIOTT: I'd rely on Martha to correct me if I'm out of bounds here, but there is -- the evaluation panel will deal with this, but the contracting officer and their group will deal with the review of past performance and government performance, and a review of financial stature, I guess, is the term. Is that correct, Martha?

MS. DiMUZIO: (Nods head affirmatively.)

MR. ELLIOTT: Yeah. So the evaluation panel won't review financial documentation, but the

contracting officers do that.

DR. ZIEMER: But it has to be provided, which --

MR. ELLIOTT: It has to be, yeah, as part of the provision under the RFP.

DR. ZIEMER: Thank you.

MR. ELLIOTT: Let me also, while I've got the mike here, just go on record to make this comment for the Board's edification. The -- all we can say at this point about the technical evaluation panel, and all the Board can say is that the panel will be made up of government employees and nongovernment folks. We can't talk about the composition of the panel, or who those nongovernment persons would be, so you cannot go away from this table and speak about this. It's off limits.

DR. ZIEMER: Including any discussions that were held during the executive session --

MR. ELLIOTT: That's correct.

DR. ZIEMER: -- last time.

MR. ELLIOTT: Once the award is made, then we will be in a position to speak to the affiliations of the panel members, but not the individual identifications, so we can speak to who served on the panel as far as their affiliations.

Does everybody understand? Thank you.

DR. ZIEMER: Thank you, Larry. Is there a question on that?

MS. MUNN: No. But I have one very minor point. Mark, could we -- could we replace the date on your document as 2/2/03 because I know that two months from now I will have a hard time remembering whether what I have here with draft 1/31 on it came before --

DR. ZIEMER: Let's call it 2/6/03.

DR. MELIUS: Yeah.

DR. ZIEMER: So mark your document so you recall this is the document we reviewed today. Thanks for that.

Is the Board ready to act on the motion before us, which is to adopt this revised language for Attachment A?

MS. ROESSLER: Yes.

DR. ZIEMER: It appears that you are ready to vote. All in favor, say aye.

BOARD MEMBERS: Aye.

DR. ZIEMER: Are there any opposed?

(No response.)

DR. ZIEMER: No. Any abstentions?

(No response.)

DR. ZIEMER: Then the record will show that the Board has approved this, and we thank the working group for handling that for us.

Are there any other matters to come -- well, let me give one more opportunity. Is there anyone from the general public that wishes to speak? Is there anyone from the general public still here?

(No response.)

DR. ZIEMER: Are there any items for the good of the order?

(No response.)

DR. ZIEMER: If not, we stand adjourned.

(Whereupon, the above-entitled proceedings were adjourned at 1:51 p.m.)

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C E R T I F I C A T E

STATE OF GEORGIA)

COUNTY OF FORSYTH)

I, Debbie G. Williams, Certified Court Reporter in and for the State of Georgia, do hereby certify that the foregoing proceedings were taken down by me; that the foregoing proceedings were reduced to print by me; that the foregoing VOLUME II, consisting of pages 263 through 413 represent a true, correct and complete transcript of the proceedings; that I am not a relative, employee, attorney or counsel of any of the parties; that I am not a relative or employee of attorney or counsel for any of said parties; nor am I financially interested in the outcome of the action.

This certification is expressly withdrawn and denied upon the disassembly or photocopying of the foregoing transcript of the proceedings or any part thereof, including exhibits, unless said disassembly or photocopying is done by the undersigned certified court reporter, and the signature and original seal is attached thereto.

This, the 22nd day of February, 2003.

_____

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